Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 30, 2017	2017_539120_0028	004735-17	Follow up

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

Long-Term Care Home/Foyer de soins de longue durée

CEDARWOOD VILLAGE
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 3 & 4, 2017

An inspection (2017-573581-0002) was previously conducted January 13 to 30, 2017, and an order was issued related to resident clinical bed safety assessments. The conditions laid out in the order were not fully complied with and the order remains outstanding.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care and RAI-MDS Co-ordinator.

During the course of the inspection, the inspector toured the home and randomly selected residents who used one or more bed rails, observed their bed systems and reviewed their clinical records.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that residents were assessed where bed rails were used in accordance with prevailing practices to minimize risk to the resident.

The prevailing practice identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada) was identified by the Ministry of Health and Long Term Care in 2012 and provides the necessary guidance in establishing a clinical assessment where bed rails are used.

An inspection (2017-573581-0002) was previously conducted January 13 to 30, 2017, and non-compliance identified with this section related to resident clinical assessments where bed rails were used. An order with multiple conditions was issued on February 23, 2017, for a due date of May 1, 2017. The order included requirements to amend the home's existing forms to include all relevant questions and guidance related to bed safety hazards identified in the above noted clinical guidance document. The requirement was confirmed to be outstanding and the licensee's bed rail use clinical assessment form and processes were determined to not be fully developed in accordance with the clinical guidance document identified above.

Four residents (#001, 002, 003, 004) were randomly selected during this inspection to determine if they were assessed for bed safety risks. According to the RAI-MDS co-ordinator, the number of residents using bed rails had been reduced substantially, however approximately 25 residents remained to be assessed.

The clinical assessment process with respect to bed rails did not include, firstly, what key risk factors were included in the decision making process during a specified sleep observation period when the resident was in bed with one or more bed rails applied and secondly, the alternatives that were trialled prior to the application of bed rails for any of the four above noted residents was not documented.

The RAI-MDS co-ordinator developed a form titled "Evaluation For Use of Side Rails" (EFUSR) for use by herself and registered nurses to assess residents either upon admission, change in condition or at a specified frequency. The EFUSR form included several categories for completion including reasons for considering bed rails (safety, security or other), medical symptoms, if the bed rails could assist the resident with bed mobility, the type of bed rail being recommended and the frequency for use.

The information gathered on the forms did not include any information about the outcome of a sleep observation period and any associated risks, if identified. The form did not include additional questions in order to determine a level of risk associated with bed system injury such as cognitive risk, level of confusion, medical status (involuntary movements, medication use, balance and trunk control, history of falls), sleep pattern (if slept through night, health conditions and environmental factors affecting quality of sleep, independent use of bed rails). An alternatives section was not included on the form, where a list of available alternative options to bed rails could be selected, the dates trialled, the person responsible for monitoring the alternative and whether the alternative was effective or not.

A written policy and procedure related to bed safety clinical assessments was not available for review, as it was not developed. The RAI-MDS co-ordinator therefore verbally reviewed the general process in assessing residents. The personal support workers (PSWs) were asked for input about each resident by the RAI-MDS co-ordinator to determine the resident’s general bed rail use abilities. The PSWs were tasked at observing residents while in bed for various different reasons, including cognitive pattern (restless, altered perception, difficult to wake up, speech issues), pain, safety (if the resident used their bed rails), mood and behaviour (slept through the night and if they had a change in their usual sleep pattern). However, there were no questions related to what types of risks the PSWs were to be looking for while the resident was in bed with a bed rail applied (if slept with body part through the rail, if body part became lodged between mattress and bed rail, if resident climbed over the rail, if resident injured themselves on any bed system component, if part of their body was off the bed etc.).

The observations collected by the PSW did not appear to be included in the overall assessment and the conclusions based on their observations were not incorporated on the EFUSR form.

Resident #101 was admitted to the home in 2013, and their written plan of care included the use of one full bed rail on the left side for position changes while staff assisted them. The resident was not observed in bed at the time of inspection, but had one ¾ length bed rail elevated on the right side of the bed. The resident was identified to have a balance deficit, general weakness and cognitive issues, thereby raising their risk level for potential bed related injury. No documentation was available to establish what safety risks were identified, if any with bed rails applied. The resident's sleep patterns and behaviours before and after bed rails were applied, over a specified period of time were not included on the EFUSR form. No information was available to determine if alternatives were considered, and if so, which alternatives were trialled, when and if effective.

Resident #102 was admitted in 2013, and their written plan of care included the use of two full bed rails for repositioning and required staff assistance as they were unable to fully move themselves while in bed. The resident could roll on their own, but needed assistance to reposition. The resident was confused and had poor judgement. No documentation was available to establish what safety risks were identified, if any with bed rails applied. The resident's sleep patterns and behaviours before and after bed rails were applied, over a specified period of time were not included on the EFUSR form. No information was available to determine if alternatives were considered, and if so, which alternatives were trialled, when and if effective.

Resident #103 and #104 did not have a completed EFUSR form in their charts when reviewed. Both residents had a written plan of care requiring the use of two bed rails each to assist with position changes and both had a logo above their bed requiring staff to apply two bed rails when in bed. Resident #103 was cognitively impaired and had a history of falls. Resident #104 was cognitively impaired, had muscle weakness and a history of falls. The listed conditions are risk factors for increased risk of bed rail related injury. At the time of inspection, the safety risks for either resident was unknown related to bed rail use.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the clinical guidance document and lacked sufficient documentation in making a comparison between the

potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 5th day of June, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2017_539120_0028
Log No. / Registre no:	004735-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 30, 2017
Licensee / Titulaire de permis :	MAPLEWOOD NURSING HOME LIMITED 500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4
LTC Home / Foyer de SLD :	CEDARWOOD VILLAGE 500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Hastings

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To MAPLEWOOD NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_573581_0002, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following;

1. Amend the home's existing bed rail assessment forms and/or information gathering processes to include;

A) Questions that can be answered and documented by the PSWs, who have been tasked at observing residents while in bed, that are specifically related to the resident
while sleeping in bed for sleep associated behaviours or conditions associated with the potential of increasing bed related injuries after the application of any bed rails; and

B) The most appropriate alternative for the resident, including the option of soft rails (adjustable bolsters), that was trialled prior to the application of one or more bed rails (where possible) and document when the alternative(s) was trialled, who monitored the alternative and if the alternative was effective during the specified trial time period; and

2. Develop a written policy and procedure to include relevant information noted

in the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April2003) and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".

3. All direct care staff are to be informed about the written policy and procedures related to bed system evaluations and resident clinical assessments and shall be provided with face to face education that shall include as a minimum, bed entrapment zones and how they are measured, risk factors that are considered high risk for bed system injury or entrapment, the benefits versus the risks of bed rail use, alternatives to bed rail use, how to identify unsafe bed rails or other bed system components that are not in good working order and who to report the information to.

4. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories or interventions that were required to mitigate any identified bed safety hazards, the type and size of the bed rail, why it is being used, when it is to be used, how many bed rails are to be applied and on what side of the bed.

5. Develop or acquire an information and education package/fact sheet/pamphlet that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, risk factors that are considered high risk for bed system injury or entrapment, the benefits versus the risks of bed rail use, alternatives to bed rail use, the role of the SDM and consents, how beds pass or fail entrapment zone testing and the contact information for Health Canada, Medical Devices Bureau for additional information and any bed system related injury, entrapment or suspension event.

Grounds / Motifs :

1. The licensee did not ensure that residents were assessed where bed rails were used in accordance with prevailing practices to minimize risk to the resident.

The prevailing practice identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and

Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada) was identified by the Ministry of Health and Long Term Care in 2012 and provides the necessary guidance in establishing a clinical assessment where bed rails are used.

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Resident #101 was admitted to the home in 2013, and their written plan of care included the use of one full bed rail on the left side for position changes while staff assisted them. The resident was not observed in bed at the time of inspection, but had one ¾ length bed rail elevated on the right side of the bed. The resident was identified to have a balance deficit, general weakness and cognitive issues, thereby raising their risk level for potential bed related injury. No documentation was available to establish what safety risks were identified, if any with bed rails applied. The resident's sleep patterns and behaviours before and after bed rails were applied, over a specified period of time were not included on the EFUSR form. No information was available to determine if alternatives were considered, and if so, which alternatives were trialled, when

and if effective.

Resident #102 was admitted in 2013, and their written plan of care included the use of two full bed rails for repositioning and required staff assistance as they were unable to fully move themselves while in bed. The resident could roll on their own, but needed assistance to reposition. The resident was confused and had poor judgement. No documentation was available to establish what safety risks were identified, if any with bed rails applied. The resident's sleep patterns and behaviours before and after bed rails were applied, over a specified period of time were not included on the EFUSR form. No information was available to determine if alternatives were considered, and if so, which alternatives were trialled, when and if effective.

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The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the clinical guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.
This Order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The factors include severity, scope and compliance history.
In relation to s. 15(1) of Ontario Regulation 79/10, the severity of the non-compliance has the potential to cause harm to residents, the scope is wide spread as all of the residents have not been assessed in accordance with prevailing practices and the compliance history is on-going as a VPC was issued on August 11, 2014 and May 9, 2016 and an order was previously issued on February 23, 2017.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of May, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

Service Area Office / Bureau régional de services : Hamilton Service Area Office