Ontario

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
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Télécopieur: (613) 569-9670

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
Nov 16, 2016	2016_505103_0051	031994-16	Critical Incident System

Licensee/Titulaire de permis

CROWN RIDGE HEALTH CARE SERVICES INC
106 CROWN STREET TRENTON ON K8V 6R3

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

CROWN RIDGE PLACE
106 CROWN STREET TRENTON ON K8V 6R3

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 7, 8, 10, 2016.

During the course of the inspection, the inspector(s) spoke with Personal support workers, a Registered Nurse, a Maintenance worker, the Director of Care, the Administrator of Westgate Lodge, and the home's owner.

During the inspection, the inspector conducted a walking tour of the unit, observed the home's assessment of bed systems related to bed entrapment, reviewed a resident health care record and the home's policy related bed safety and the use of bed rails.

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 where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the resident.

On an identified date, resident #001 was found by PSW #100 entraped between the half side rail and the mattress. The PSW called for help and RN #101 attended to the resident. The resident was assessed as having no vital signs and the coroner was notified of the unexpected death.

PSW #102 was interviewed and indicated she had been assigned to care for resident #001 on the evening shift just prior to the entrapment. The PSW recalled being in the resident room at approximately 2100 hour when she attended to the roommate. She indicated resident #001 was lying on their left side in bed facing the door, both half rails were up, the resident's clip alarm was on, the bed was in the lowest position and a fall mat was on the floor on the window side of the bed. The PSW stated she asked the resident how they were and the resident responded they were good. The PSW indicated resident #001 could roll independently from side to side in bed and that she never saw the resident utilize the bed rails when in bed. PSW #102 indicated at approximately 2145, she walked past the room on her final round and could see the resident was in bed at that time.

The resident health care record was reviewed and indicated resident #001 had resided in the home for an identified period of time and had identified diagnoses. The resident plan of care in effect at the time of this incident, indicated:

Under "ADL self care performance deficit"-requires staff assistance to reposition and turn in bed and uses assistive device-half side rails to reposition and turn in bed, and
-encourage use of bed rails to assist with turning.

The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified below.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document included the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggested that the documents were "useful resources".

One of the companion documents was titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations were made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) were a safe device for residents while in bed (when fully awake and while they are asleep).

The Clinical Guidance document also emphasized the need to document clearly whether alternative interventions were trialled if bed rails were being considered. Where bed rails are considered for transferring and bed mobility, it recommended that discussions needed to be held with the resident/substitute decision maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed) and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required,

when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The Director of Care was interviewed in regards to the home's process for assessing residents that use bed rails. She indicated resident #001 utilized the two half rails as a Personal Assistance Services Device (PASD) to assist the resident in turning from side to side while in bed. The DOC provided the inspector with the home's assessment tool, titled "Bed Safety Checklist for Resident Use, policy #NPPM: 4.14b and indicated it was to be completed on admission and on a quarterly basis. Resident #001 had been last assessed for the use of bed rails on August 18, 2016 as a part of a quarterly review. The DOC indicated the registered nurse was responsible for completing this in collaboration with the resident/substitute decision maker.

RN #101 was interviewed and indicated upon admission and on a quarterly basis, the resident and the SDM would be asked whether they wanted bed rails to be used. She indicated sometimes the family members or residents would request the bed rails to prevent them from falling out of bed. The RN indicated as a part of the bed safety assessment, a series of questions related to the use of an electric bed would be asked. Resident #001's bed safety checklist was reviewed and indicated the resident lacked the understanding of their electric bed and therefore, would have the remote placed on the bed out of reach of the resident. RN #101 indicated this was to avoid the resident from using the remote to change the bed position in an unsafe manner such as raising the bed height. Under "bed rail safety", the bed safety checklist had three questions:

(1) Is the resident able to use the bed rail as an assistive device to bed mobility?
(2) Is the side rail used as a reminder to the resident to call or wait for staff assistance? and
(3) Is the side rail used as a restraint for the resident?

Resident #001's bed safety checklist indicated "yes" to question one and "no" to questions two and three.

RN #101 stated if a resident or SDM wanted bed rails to be used, a consent would be signed which would indicate if the bed rails were a restraint or a PASD. The RN indicated the bed rails would be considered a PASD as long as the resident did not code higher than a "three" for bed mobility in MDS. A "three" for bed mobility indicated the resident required extensive assistance with bed mobility which was defined as the resident

performed part of the activity over the past 7 days but required help with weight–bearing support and others three or more times during the past 7 days. If a resident was coded a "four" for bed mobility in MDS, it indicated the resident required total assistance of staff. The RN stated the resident's ability to grip the bed rail was another area taken into consideration when assessing for the use of bed rails and that resident #001 was able to grip the rails and was coded as a "three" under bed mobility.

RN #102 stated resident #001 was at risk of falls and had a low bed and fall mat in place. She indicated the resident had been found many times on the fall mat and she believed the resident preferred to sleep close to the edge of the mattress. She stated she believed this was part of the reason the half rails were required to prevent the resident from rolling out of bed. The RN also stated the resident's cognition had slowly declined since admission to the home.

PSW #100 was interviewed and indicated resident #001 usually required limited staff assistance when turning from side to side and could use the bed rails to assist with the turn. The PSW did state more assistance would be required for turning when the resident was in a deep sleep. PSW #100 had also observed resident #001, on occasion, leaning over the side of the bed.

The above noted risks related to the resident's sleeping position while in bed, the slow decline in cognition, the need for increased assistance to turn when in a deep sleep or the resident's behaviour related to leaning over the edge of the bed were not outlined in the resident plan of care. In addition, the Bed Safety Checklist used on August 18, 2016 did not include any questions or considerations to assess these risks.

The DOC was interviewed in regards to alternatives to bed rails that may have been tried. She indicated she was unaware of any alternatives tried for resident #001 and was unable to find any supporting documentation. The DOC was asked about the number of residents who utilized bed rails in the home and she stated she believed the majority of residents used two half bed rails. This inspector observed evidence of this during a walk-through of the unit.

The decision to issue this non compliance as an order was based on the following:
The severity was assessed as actual harm to resident #001 and the scope was assessed as widespread as it was determined the majority of residents living in this home utilized two half rails without having a comprehensive bed rail assessment completed in accordance with the best practice guidelines. [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 16th day of November, 2016

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

Original report signed by the inspector.

Ontario

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) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2016_505103_0051
Log No. / Registre no:	031994-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 16, 2016
Licensee / Titulaire de permis :	CROWN RIDGE HEALTH CARE SERVICES INC 106 CROWN STREET, TRENTON, ON, K8V-6R3
LTC Home / Foyer de SLD :	CROWN RIDGE PLACE 106 CROWN STREET, TRENTON, ON, K8V-6R3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sandra Honey

To CROWN RIDGE HEALTH CARE SERVICES INC, 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)

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 is hereby ordered to complete the following:

1. Amend the home's existing "Bed Safety Checklist for resident use" to include all relevant questions and guidance related to bed safety hazards found in 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, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". The amended questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternatives were effective or not during an observation period.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment and document the assessed results and recommendations for each resident.

3. 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 that may be required to mitigate any identified bed safety hazards.

Grounds / Motifs :

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

On an identified date, resident #001 was found by PSW #100 entraped between the half side rail and the mattress. The PSW called for help and RN #101 attended to the resident. The resident was assessed as having no vital signs and the coroner was notified of the unexpected death.

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resident #001 on the evening shift just prior to the entrapment. The PSW recalled being in the resident room at approximately 2100 hour when she attended to the roommate. She indicated resident #001 was lying on their left side in bed facing the door, both half rails were up, the resident's clip alarm was on, the bed was in the lowest position and a fall mat was on the floor on the window side of the bed. The PSW stated she asked the resident how they were and the resident responded they were good. The PSW indicated resident #001 could roll independently from side to side in bed and that she never saw the resident utilize the bed rails when in bed. PSW #102 indicated at approximately 2145, she walked past the room on her final round and could see the resident was in bed at that time.

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all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) were a safe device for residents while in bed (when fully awake and while they are asleep).

The Clinical Guidance document also emphasized the need to document clearly whether alternative interventions were trialled if bed rails were being considered. Where bed rails are considered for transferring and bed mobility, it recommended that discussions needed to be held with the resident/substitute decision maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed) and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

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The decision to issue this non compliance as an order was based on the following:
The severity was assessed as actual harm to resident #001 and the scope was assessed as widespread as it was determined the majority of residents living in this home utilized two half rails without having a comprehensive bed rail assessment completed in accordance with the best practice guidelines. [s. 15. (1) (a)]

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 09, 2016

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 16th day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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