Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: April 13, 2023
Inspection Number: 2023-1224-0004
Inspection Type: Complaint Critical Incident System
Licensee: Gibson Holdings (Ontario) Ltd.
Long Term Care Home and City: Helen Henderson Nursing Home, Amherstview

Lead Inspector	**Inspector Digital Signature**
Anna Earle (740789)	Anna M Earle Digitally signed by Anna M Earle Date: 2023.04.27 10:02:34 -04'00'

Additional Inspector(s)
Carrie Deline (740788)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3-5, 2023

The following intake(s) were inspected:

- Intake: #00015411 - CI 2728-000006-22: Resident fall with sustained injury and transfer to hospital.
- Intake: #00016481 - Complaint regarding bed rails.
- Intake: #00022303 - CI 2728-000002-23 Misuse/Misappropriation of a resident's money.
- Intake: #00022473 - Complaint regarding a fall of a resident.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints

Falls Prevention and Management
Resident Charges and Trust Accounts
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bed Rails

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)

The licensee has failed to ensure that when resident #004 used bed rails, the resident was assessed in accordance with prevailing practices, to minimize risk.
A document titled "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) provides the necessary guidance in establishing a clinical assessment where bed rails are used. The guide is cited in another document developed by Health Canada titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards”, March 2008. The Health Canada guide was identified by the Director of the Ministry of Long-Term Care in 2012 and 2019, as the prevailing practice with respect to bed safety and shared with the sector.

Rationale and Summary
On April 5, 2023, it was noted by Inspector #740789 and Inspector #740788 that thirty-two residents had bed rails attached to their beds.

Inspector #740789 reviewed care plans and electronic health records of residents #003, #004 and #005 and there was no indication that an assessment tool was completed or that the residents were utilizing a bed rail though bed rails were attached to their beds. Inspector #740788 reviewed hard copy of health record for resident #004 and did not find any clinical assessment tools used for the resident for the use of a bed rail. On April 5, 2023, Inspector #740789 completed an interview with RPN #106 that confirmed resident care plans do not include the use of bed rails as the bed rails are not used as a restraint. During an interview with

Inspector #740789 on April 4, 2023, DOC #101 and Care Coordinator #102 confirmed that the use of bed rails is not added to the resident's plan of care as the bed rails are not used as a restraint and resident assessments are only completed if there is a suspected risk to the resident.

Residents using bed rails without assessment of the resident and the bed rail system, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, places the resident at risk for injury and/or entrapment.

Sources: Resident #004 electronic and hard copy health record, care plans for residents #003, #004 and #005, interviews with DOC #101, Care Coordinator #102 and RPN #106

[740789]