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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 12, 2017	2017_57610a_0006	005368-17	Resident Quality Inspection

Licensee/Titulaire de permis

IDLEWYLD MANOR
449 SANATORIUM ROAD HAMILTON ON L9C 2A7

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

IDLEWYLD MANOR
449 SANATORIUM ROAD HAMILTON ON L9C 2A7

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

IRENE SCHMIDT (510a), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 13, 15, 16, 17, 20, 21 and 22, 2017.

During this RQI, follow up inspections, log #032292-16 (O. Reg. 79/10, 6(10) and #032293-16 (O. Reg. 79/10, 110(1)(1), and critical incident inspections, log #034170-16 (staff to resident abuse), #034591-16 (staff to resident abuse) and #006007-17 (staff to resident abuse), were inspected.

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW), food service staff, food service manager, registered practical nurses (RPN), registered nurses (RN), Director of Nursing (DON) and the Administrator.
In addition, inspectors toured the home, observed general maintenance and confirmed the posting of required information. Inspectors also observed the provision of resident care, resident/staff interactions, medication administration, medication storage areas, recreation activities. Relevant clinical records, including the review of relevant policies and procedures, was also undertaken.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (1)	CO #002	2016_343585_0013	510a
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2016_343585_0013	585

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 has failed to ensure that where bed rails were used, (a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

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 includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. One of the companion documents is 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 are 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) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also

emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need 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 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.

A) On an identified date, the resident's bed was observed to have one bed rail in place. Registered staff #109 confirmed that the resident had one bed rail up, when in bed. The document the home refers to as the care plan and the kardex also provided this direction. Review of the clinical record revealed the absence of a bed system evaluation or any documented assessment of the resident, while in the bed, awake and asleep, to determine if the bed rails were a safe device for the resident. Registered staff #112 confirmed that during admission processes with residents, many resident specific assessments are completed. Staff #112 further stated they were not familiar with a clinical bed rail assessment being completed as part of that process. Personal support staff #114, reported they observe residents with bed rails, during the night and report any concerns to registered staff, but did not complete documentation of sleep patterns for residents with side rails, as part of a bed rail assessment. The Director of Nursing (DON) and the Administrator, confirmed the home does not have a bed rail clinical assessment form, developed in accordance with the Clinical Guidance document, identified above. The resident who had a bed rail when in bed, was not assessed in accordance with evidence based practices, to minimize risk to the resident.
B) Resident #007's bed was observed to have one bed rail and on interview, the resident confirmed that when they are in bed, they have one bed rail up. Review of the document the home referred to as the care plan, and kardex, provided direction for one bed rail up when the resident was in bed. Review of the clinical record revealed the absence of a bed system evaluation or any documented assessment of the resident, while in the bed,

awake and asleep, to determine if the bed rails were a safe device for the resident. Registered staff #112 confirmed that they conduct admission processes with residents and that in the first 24 hours, many resident specific assessments are completed. Staff #112 stated they were not familiar with clinical bed rail assessment being completed for residents requesting bed rails. Personal support staff #114, reported they observe residents at night, with bed rails, and report any concerns to registered staff, but did not complete documentation of sleep patterns for residents with bed rails, as part of a bed rail assessment.
The Director of Nursing (DON) and the Administrator, confirmed the home does not have a bed rail clinical assessment form, developed in accordance with the Clinical Guidance document, identified above.
Resident #007, who has a bed rail when in bed, was not assessed in accordance to evidence based practices, to minimize risk to the resident.
C) On an identified date, resident #015 was observed resting in bed, with one bed rail raised. PSW # 115 and PSW # 116 confirmed the bed rail was used when the resident was in bed. The Director of Nursing (DON) and the Administrator, confirmed the home does not have a bed rail clinical assessment form, developed in accordance with the Clinical Guidance document, identified above.
Review of the resident's clinical record did not include any bed rail assessment that identified the use of one bed rail. RPN #117 and RPN #118 confirmed the resident used one bed rail as per family's request for comfort and reported bed rail assessments were not completed when residents used one bed rail. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. In accordance with Ontario Regulation (O. Reg) 79/10, r. 68. (2) requires every licensee of a long-term care home to ensure that as part of the organized program of nutrition care and dietary services:
(a) policies and procedures relating to nutrition care and dietary services and hydration, in consultation with a registered dietitian who is a member of the staff of the home, are developed and implemented;
(d) there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) there is a weight monitoring system to measure and record with respect to each resident (i) weight on admission and monthly thereafter.

A) The home's job routine for morning dietary staff identified dietary aides were to serve breakfast following the therapeutic menu and kardex.
At an identified time and place, during meal service, PSW #108 was observed behind the servery, scooping hot food for a resident. The PSW was using a large silver spoon that was not a therapeutic scoop that indicated portion size. The serving table was turned off and warm to touch. PSW #108 reported they did not work in the home as dietary staff. They continued to serve a resident. Long-Term Care (LTC) Homes Inspector #585 asked PSW #108 what the resident's dietary requirements were, and the PSW was unable to report and confirmed they relied on information communicated to them by PSW staff. PSW #108 was unable to report what was on the therapeutic menu for the meal and was unaware the serving table was off. PSW #108 was not able to identify what residents dietary requirements were, locate or use the serving notes to direct dietary staff at meal time, use appropriate serving utensils, or ensure food was served at an appropriate temperature. In addition, during the same meal, resident #017, who required extensive assistance with eating, was not provided assistance from nursing staff for 40

minutes.
Interview with dietary staff #106 and dietary staff #107 reported when residents came late to the dining room, nursing staff were expected to inform dietary staff of late meal requests, so dietary staff could serve residents the appropriate therapeutic diet. Dietary staff #107 also confirmed information outlined in the meal serving notes used by dietary staff contained more information than the snack cart serving notes used by PSWs. The FSM confirmed only dietary staff were to serve meals to residents.
B) The home's policy, "Weight Monitoring Program – RC 03-01-08", revised January 18, 2017, directed nursing staff to weigh residents on the first bath day of the month with the same appropriate scale for the resident. The weight is to be documented on the monthly weight sheets. All weights are documented by the 7th of each month. Significant (5 pounds (lbs)/2.2 kilograms (kg)) discrepancies in weight prompt a re-weigh. Results are to be inputted into Point Click Care by the RPN/RN on nights by the 7th of the month and re-weights are to be entered as they are completed by the RPN on the unit. Food services/Dietitian will check PCC by the 10th of the month to access residents with a 5 per cent loss or gain in one month, as per nursing policy.
i) Review of resident # 003's weight record revealed their initial measurement for an identified month was not completed until the 18th of the month, at which time, the resident was measured and experienced a weight loss of greater than 2.2 kg. The RD was made aware of the weight change and ordered a re-weigh, which was obtained three days later. The RD confirmed the resident's weight was not monitored in accordance with their policy.
ii) Review of resident #017's weight record revealed an initial measurement was made on an identified date, at which time they triggered a 10.5 per cent loss over one month. The resident was not re-weighed until 13 days later, at which time the significant weight change was confirmed. The RD confirmed the home did not follow their policy to complete a prompt re-weigh.
Interview with the RD confirmed the weights for resident #003 and resident #017's were not monitored in accordance with the home's policy.
C) The home's policy, "Hydration Monitoring, RC 05-08-02", revised January 25, 2017, stated fluid records for each resident should be reviewed nightly by registered staff. If a resident did not meet the minimum goal range number, it was to be indicated on the monitoring sheet, oncoming staff were to be told to encourage the resident's fluid intake and document fluid intake. If the resident already had two consecutive marks and was not meeting the minimum goal range number on day three, a hydration assessment progress note was to be completed and indicated on the monitoring sheet.
Review of resident #003's fluid intake report for an identified 18 day period, revealed they did not meet their minimum fluid goal range for 3 consecutive days, on two occassions,

during this time frame. Review of the fluid intake monitoring sheet revealed that for each of these occassions, registered staff did not indicate on day two, that the resident did not meet their minimum fluid goal range number. As a result, after the third day of not meeting their minimum fluid goal, registered staff were not prompted to complete a hydration assessment progress note. Registered staff #109 confirmed on two occasions during an identified time frame, resident #003's hydration status was not monitored in

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or
system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy
or system, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

A) At admission, resident #005's admission minimum data set (MDS) score for continence reported the resident was continent of bowels and frequently incontinent of bladder. The MDS score three months later revealed a decline in continence, reporting the resident was incontinent of bowels and bladder. Review of the clinical record for resident #005 revealed the absence of an admission continence assessment or any subsequent continence assessments.
The Home's policy #RC-11-04-01, titled Continence Care and Bowel Management Program and approved 2017/02/14, directed that registered staff would conduct a bowel and bladder continence assessment using a clinically appropriate instrument on admission, quarterly and after any change in condition that may affect bowel or bladder continence.
Resident #005 did not receive a continence assessment using a clinically appropriate assessment instrument, at admission, or when there was a change in bowel and bladder continence, as confirmed by the Director of Care (DOC).
B) At admission, resident #006 had an admission minimum data set (MDS) score for continence that reported the resident was occasionally incontinent. The MDS score three months later revealed a decline in continence, reporting the resident was frequently incontinent. Review of the clinical record for resident #006 revealed the absence of an admission continence assessment or any subsequent continence assessments.
The Home's policy #RC-11-04-01, titled Continence Care and Bowel Management Program and approved 2017/02/14, directed that registered staff would conduct a bowel and bladder continence assessment using a clinically appropriate instrument on admission, quarterly and after any change in condition that may affect bowel or bladder continence.
The admission MDS assessment for resident #006, indicated the resident was occasionally incontinent of urine. The MDS score three months later reported the resident was frequently incontinent of urine, representing a decline in bladder continence. Resident #006 did not receive a bladder continence assessment using a clinically appropriate assessment instrument, at admission, or when there was a change in bladder continence, as confirmed by the Director of Care (DOC). [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is incontinent receives a continence assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was provided with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Review of resident #017's plan of care related to eating identified they were at high nutrition risk, and required assistance with eating to maintain maximum self-sufficiency for eating related to identified deficits. The plan identified interventions, including to provide a lip plate, cups with lids and a straw and to monitor for signs of difficulty eating. Review of their weight record history revealed on a specified date, they experienced a weight loss of 11 per cent over six months.
Review of a progress note by the Registered Dietitian (RD) on an identified date, included documentation of specific behaviors and the RD recommended not providing paper napkins unless PSWs were present.
On an identified date and time, resident #017 was observed sitting alone at their table in the dining room for breakfast with cereal in front of them. Two nursing staff were observed in the dining room: RPN #120, who was administering medications to residents in the dining room and PSW #121 who was providing total assistance to a resident on the other side of the dining room, with their back toward resident #017. The resident's fluids were served; however, not served with lids and straws.
During a 15 minute period, the resident was observed with a paper napkin in their hand and no PSW present. During this time, the resident was observed with toast with jam and eggs on a regular plate in front of them. As the resident attempted to eat their hot meal, food was observed falling onto the ground. The resident attempted to pick the fallen items off the floor. Ten minutes later, the resident moved themself into the servery, and then appeared to be attempting to move back to the table. Thirty minutes after the resident first received their hot breakfast, PSW #120 approached resident #017, sat down and started to assist the resident. Ten minutes later, the resident was out of the dining room, and noted to have consumed less than 25 percent of their meal and half a glass of orange juice.
Interview with RPN #120, who reported they were present when resident #017 was in the dining room, confirmed resident #017 required extensive assistance with eating. PSW #120 confirmed resident #017 was not provided appropriate assistance with eating for 40 minutes.
Dietary staff #107 reported they did not serve the resident's meal on a lip plate as the resident received total assistance with eating and therefore did not require it. Dietary staff #107 confirmed their serving notes indicated the resident's meal was to be served on a lip plate, fluids with a lid and straw and no paper napkin. (585) [s. 73. (1) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are provided the identified eating aids, assistive devices and personal assistance, as set out in the plan of care, to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

On an identified date, resident #015 was observed in bed with one bed rail raised. A pictograph in their room on the door frame also indicated they used one bed rail. Personal support worker (PSW) #115 and PSW #116 confirmed the resident used one bed rail when in bed.
Review of the resident's clinical record revealed a Minimum Data Set (MDS) assessment, coded the resident as 'other types of side rails used (e.g., half rail, 1 side)', daily; however, a Restraints/PASD/Alternatives assessment, noted they did not use bed rails. On an identified date, the written plan of care, including the care plan and kardex, was reviewed and did not include the use of a bed rail. Interview with the Resident Assessment Instrument (RAI) coordinator confirmed the Restraints/PASD/Alternatives assessment was not consistent with or complemented other areas of documentation and assessments where staff would identify the use of bed rails. Registered staff #117 confirmed the written plan of care, which included the care plan, kardex and pictograph was also inconsistent regarding the use of the bed rails. (585) [s. 6. (4) (a)]

Issued on this 12th day of April, 2017

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) :	IRENE SCHMIDT (510a), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2017_57610a_0006
Log No. / Registre no:	005368-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 12, 2017
Licensee / Titulaire de permis :	IDLEWYLD MANOR 449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7
LTC Home / Foyer de SLD :	IDLEWYLD MANOR 449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Maureen Goodram

To IDLEWYLD MANOR, 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 shall complete the following:
1. Develop and implement a bed rail assessment form 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 questionnaire shall, at a minimum, include:
a) questions that can be answered by the assessors related to 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 the application of one or more bed rails and document whether the alternatives were effective during the specified period of time; and
c) include the names of the interdisciplinary team members who participated in evaluating the resident; and
d) provide clear written direction or alternative (i.e decision tree) to assist the assessor(s) in answering the questions when determining whether bed rails are a safe alternative for the resident being assessed.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the newly developed bed safety assessment form 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 newly developed 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.
4. Obtain or develop an education and information package that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, how beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts associated with bed systems and the use of bed rails.
5. Ensure the home's "Bed Rails" policy and associated forms and Procedures, include all of the above noted requirements and any additional 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, April 2003) and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". All registered and non-registered staff shall be informed about the amended policy, forms and procedures.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, (a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

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 includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing

practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. One of the companion documents is 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 are 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) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need 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 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.

A) On an identified date, the resident's bed was observed to have one bed rail in place. Registered staff #109 confirmed that the resident had one bed rail up, when in bed. The document the home refers to as the care plan and the kardex also provided this direction. Review of the clinical record revealed the absence of a bed system evaluation or any documented assessment of the resident, while in the bed, awake and asleep, to determine if the bed rails were a safe device for the resident. Registered staff #112 confirmed that during admission processes with residents, many resident specific assessments are completed. Staff #112 further stated they were not familiar with a clinical bed rail assessment being completed as part of that process. Personal support staff

#114, reported they observe residents with bed rails, during the night and report any concerns to registered staff, but did not complete documentation of sleep patterns for residents with side rails, as part of a bed rail assessment. The Director of Nursing (DON) and the Administrator, confirmed the home does not have a bed rail clinical assessment form, developed in accordance with the Clinical Guidance document, identified above.
The resident who had a bed rail when in bed, was not assessed in accordance with evidence based practices, to minimize risk to the resident.
B) Resident #007's bed was observed to have one bed rail and on interview, the resident confirmed that when they are in bed, they have one bed rail up. Review of the document the home referred to as the care plan, and kardex, provided direction for one bed rail up when the resident was in bed. Review of the clinical record revealed the absence of a bed system evaluation or any documented assessment of the resident, while in the bed, awake and asleep, to determine if the bed rails were a safe device for the resident. Registered staff #112 confirmed that they conduct admission processes with residents and that in the first 24 hours, many resident specific assessments are completed. Staff #112 stated they were not familiar with clinical bed rail assessment being completed for residents requesting bed rails. Personal support staff #114, reported they observe residents at night, with bed rails, and report any concerns to registered staff, but did not complete documentation of sleep patterns for residents with bed rails, as part of a bed rail assessment.
The Director of Nursing (DON) and the Administrator, confirmed the home does not have a bed rail clinical assessment form, developed in accordance with the Clinical Guidance document, identified above.
Resident #007, who has a bed rail when in bed, was not assessed in accordance to evidence based practices, to minimize risk to the resident.
C) On an identified date, resident #015 was observed resting in bed, with one bed rail raised. PSW # 115 and PSW # 116 confirmed the bed rail was used when the resident was in bed. The Director of Nursing (DON) and the Administrator, confirmed the home does not have a bed rail clinical assessment form, developed in accordance with the Clinical Guidance document, identified above.
Review of the resident's clinical record did not include any bed rail assessment that identified the use of one bed rail. RPN #117 and RPN #118 confirmed the resident used one bed rail as per family's request for comfort and reported bed rail assessments were not completed when residents used one bed rail. [s. 15. (1) (a)]
(510a)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 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 12th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Irene Schmidt

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