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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 27, 2019	2019_665551_0011	024898-18, 029599-18, 030192-18, 000222-19, 001210-19, 001566-19, 002622-19, 003065-19, 003377-19, 004116-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Lanark
c/o Lanark Lodge 115 Christie Lake Road PERTH ON K7H 3C6

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

Lanark Lodge
115 Christie Lake Road, R. R. #4, Lot 27, Concession 2 PERTH ON K7H 3C6

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

MEGAN MACPHAIL (551), JESSICA LAPENSEE (133)

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): May 27-31 and June 3-7, 2019.

The following logs were inspected:

- related to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status:
024898-18 / Critical Incident Report (CIR) M548-000025-18
001566-19 / CIR M548-000004-19
002622-19/ CIR M548-000006-19

- related to allegations of resident to resident abuse:
029599-18 / CIR M548-000034-18
030192-18 / CIR M548-000035-18
001210-19 / CIR M548-000002-19
003065-19 / CIR M548-000007-19
003377-19 / CIR M548-000008-19

- related to a missing/unaccounted controlled substance: 004116-19 / CIR M548-000009-19

- related to a Follow-up to Compliance Order (CO)#001, issued under s. 15. (1) from inspection #2018_765541_0019: 000222-19

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Nursing Staff, the Quality MDS Co-ordinator, the Physiotherapist, Maintenance Workers, the Environmental Services Manager, an Associate Director of Care, the Acting Director of Care, the Director of Care and the Director.

During the course of the inspection, the inspector(s) reviewed residents' health care records, observed residents' bed systems, observed entrapment zone testing on residents' bed systems, reviewed documentation related to entrapment zone testing and observed resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
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	Légende 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 comply with compliance order (CO) #001 from Complaint Inspection #2018_765541_0019. The CO report date was January 2, 2019, and the CO originally had a compliance due date (CDD) of March 1, 2019. The CDD was subsequently extended, upon request from the licensee. The final CDD was May 15, 2019.

The licensee was ordered to comply with O. Reg. 79/10, s. 15 (1), and, to specifically comply with the following items:

1) Ensure that bed rail use for resident #001, #002, #006 and any other resident is assessed and implemented in full accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) (FDA clinical guidance document). This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment, following the resident assessment by the interdisciplinary team, where bed rails are in use. The documented risk benefit

assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion, if bed rails are used, indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

2) Ensure that steps are taken and documented to prevent resident entrapment for residents #001, #002, #006 and any other resident, taking into consideration all potential zones of entrapment.

The licensee failed to complete step 1 in that bed rail use was not assessed in accordance with the FDA clinical guidance document.

The licensee completed step 2 in that the “M-Rail home bed assist handles” were removed from all residents’ bed systems.

In relation to evidence based and prevailing practices:

In August, 2012, the Ministry of Health and Long-Term Care (MOHLTC) issued a memo to all Long-Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards” (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

The HC guidance document includes the titles of two additional companion documents. The referenced companion documents are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is a clinical practice guideline, titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals,

Long Term Care Facilities and Home Care Settings, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used. The other companion document is titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006, FDA".

On March 27, 2019, the MOHLTC issued another memo to the Long-Term Care Home sector about the use of bed rails in long term care homes. The memo included reference and links to the three documents noted above, as well as a summary of expectations related to assessing residents and evaluating bed systems.

Related to the evaluation of residents' bed systems, where bed rails are used, in accordance with evidence-based practices to minimize risk to the residents:

It is noted that with one exception, the type of bed rails in use in the home at the time of the inspection are referenced by the home as bed helpers (a.k.a pivot assist devices). Entrapment zones 1, 2, 3 and 4 exist with this type of bed rail and as such bed system evaluation remains a requirement, including testing of the above referenced entrapment zones.

On May 31, 2019, Inspector #133 observed resident #013's bed system. There was a bed helper (BH) on the right side of the bed, and there was a gap of approximately 3.5 inches between the side of the mattress and the BH (entrapment zone 3). This was in contrast to other observed bed systems with a BH, where the BH was typically flush with the side of the mattress. On June 6, 2019, maintenance worker #115 conducted entrapment zone testing on resident #013's BH and it was determined that zone 3 failed. Maintenance worker (MW) #115 noted that the mattress on the bed was highly compressible (Pressure Pedic). Later that day, on June 6, 2019, a firmer mattress (Geo Matt) was put into place for resident # 013. Entrapment zone testing was documented by MW #115, and zone 3 was noted to have passed. On June 7, 2019, in resident #013's bedroom, MW #116 indicated that BHs are always installed so they are flush with the side of the mattress, however, it is possible to move a BH out and away by manipulating the BH hardware under the bed. Inspector #133 observed MW #116 conduct entrapment

zone testing on resident #013's BH. The testing was done with the BH flush with the side of the new mattress, and, with the BH out and away from the side of the new mattress as it had been on June 6, 2019. Entrapment zone 3 passed in both scenarios. It was concluded by MW #116 that the combination of the highly compressible nature of the Pressure Pedic mattress and the gap between the BH and the side of the Pressure Pedic mattress had resulted in the zone 3 failure observed the previous day. It was determined that entrapment zone testing had been conducted, with the Pressure Pedic mattress and the BH fixed into position flush with the side of the mattress, and all zones had passed. It could not be determined who had moved the BH out and away from the side of the Pressure Pedic mattress, or when. It was determined that the change had not been communicated to the maintenance department, and therefore entrapment zone testing had not been conducted.

In summary; resident #013's bed system was not evaluated in accordance with evidence based practices, to minimize risk to the resident, following a change to the fixed position of the bed helper in relation to the side of the mattress.

Related to the assessment of residents, where bed rails are used, in accordance with prevailing practices to minimize risks to the residents:

As per the FDA clinical guidance document: Decisions to use or discontinue use of bed rails is to be made in the context of an individual resident assessment by an interdisciplinary team with input from the resident and family or the resident's legal representative. The factors to be included in the resident assessment are prescribed. Considering the information gathered, the team is then to complete a risk benefit assessment (as prescribed). The use of bed rails is to be based on the resident's assessed medical needs, documented clearly and approved by the interdisciplinary team. If clinical and environmental interventions have proven unsuccessful in meeting the residents assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used.

On June 3, 2019, Inspector #133 observed a BH in place on the right side of resident #014's bed. The resident's electronic health care record, and paper chart, were reviewed. The use of the BH was referenced in the resident's care plan. A Bed Rail Risk Assessment – V2 (BRRA) could not be located. Resident #014's admission checklist had been completed by Registered Practical Nurse (RPN) #117 on a specified date. On June 4, 2019, RPN #117 indicated that they had not been aware that a BH had been in

use for resident #014. RPN #117 indicated that they had not completed a BRRA upon the resident's admission. RPN #117 indicated that if a BRRA had been completed for resident #014, by anyone, it would be part of the electronic health care record. A BRRA was subsequently completed for the resident that day, by RPN #118. It was noted in the BRRA that a BH was in place when resident #014 had moved into their bedroom. As per the BRRA, and based on resident #014's identified risk factors, the decision was made to remove the BH from the resident's bed for safety purposes.

In summary, bed rail use was implemented for resident #014 in the absence of an assessment process as per the FDA clinical guidance document.

In relation to the overall assessment and decision making process in place related to bed rail use, Inspector #133 interviewed the Director of Care on June 4, 2019. Over the course of the interview, it was established that the assessment and decision making process about bed rail use was not conducted by an interdisciplinary team, it was conducted by registered nursing staff. It was established that an interdisciplinary team had been involved in the creation of the home's Bed Rail Risk Assessment – V2 (BRRA). In this way, the DOC explained, it was thought that the requirement for an interdisciplinary team approach had been satisfied. The DOC indicated that the interdisciplinary team did not reference the Compliance Order or the FDA clinical guidance document when creating the BRRA. It was noted that the BRRA did not include all specified factors as per the Compliance Order and as per the FDA clinical guidance document, such as: sleep habits; medication; communication; ability to toilet self safely; risk of falling.

On June 4, 2019, Inspector #133 interviewed Registered Practical Nurse (RPN) #117 about the BRRA that they had completed for resident #015 on March 14, 2019. The RPN indicated that it is the registered nursing staff that complete the questions on the BRAA and make a decision about bed rail use for a resident. The RPN indicated that they had completed the BRRA, with information from Personal Support Workers (PSWs). The RPN indicated that there was no team in place to consider the results of the BRRA and to make decisions. The Inspector referenced the specified factors for a resident assessment, as per the Compliance Order and the FDA clinical guidance document, to verify if some factors may have considered in the absence of a specifically related question on the BRRA. The RPN indicated they would not have considered the following factors: sleep habits; medications; ability to toilet self safely; and communication.

On June 5, 2019, while off site, Inspector #133 interviewed RPN #119 on the telephone

about the BRRA that they had completed for resident #016 on March 15, 2019. The RPN indicated that the PSWs that provided daily care to the resident felt that the resident would benefit from a BH. The RPN indicated that they recalled a nursing co-worker had looked at the questions with them, as the RPN had not yet completed a BRRA. RPN #119 indicated that they answered the questions and came to a final conclusion that a bed helper would be of benefit for the resident. The RPN indicated that there was no established team to do the assessment and to make a final decision. The RPN indicated they would not have considered the following factors: sleep habits; medications; ability to toilet self safely; communication; risk of falling.

On June 6, 2019, Inspector #133 interviewed RPN #120 about the BRRA that they had completed for resident #017 on March 15, 2019. The RPN indicated that there was a bed helper (BH) in place for the resident at the time that they completed the BRRA. The RPN indicated that there was no interdisciplinary team in place to consider the information in the BRRA. The RPN indicated that they knew resident #017 well and could answer the questions on their own when completing the BRRA. The RPN indicated that for a new resident, they would talk to others to gather any information they needed to answer the questions and to come to a conclusion. The RPN indicated they would not have considered the following factors: sleep habits; medications; ability to toilet self safely; communication; risk of falling. It was noted that the RPN had answered "Yes" to question A5 "Does the resident attempt to get out of bed unsupervised?". If answered Yes, it is indicated "consider entrapment issues & alternatives". The RPN explained to the Inspector that they thought that answering yes to this question would be indicative of a need for a BH, rather than informing about risk of entrapment.

In summary, the home's assessment and decision making process regarding bed rail use was not in accordance with the prevailing practices outlined in the FDA clinical guidance document. Where bed rails are used, residents have not been assessed in accordance with prevailing practices, to minimize risk to the resident.

In conclusion, the decision to reissue this compliance order was based on the following:

The severity of the non-compliance was such that there was actual risk of harm to resident #013 and #014, in relation to their bed systems. There was actual risk of harm to resident #015, #016, #017, and all other residents with bed rails in use, in relation to the assessment and decision making process.

The scope of the non-compliance identified was widespread, in that the bed rail use

assessment and decision making process in place was not in accordance with prevailing practices, as per the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, FDA, 2003"

Related to the licensee's compliance history, the Compliance Order (CO) is reissued to the same section and subsection, O. Reg. 79/10, s. 15 (1), related to bed rail use. CO #001 was served to the licensee in January 2019 as a result of Complaint Inspection #2018_765541_0019. The licensee has not been issued any additional COs within the last 36 months. [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 8th day of July, 2019

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

Ministère de la Santé et des Soins de longue durée

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

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) :	MEGAN MACPHAIL (551), JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2019_665551_0011
Log No. / No de registre :	024898-18, 029599-18, 030192-18, 000222-19, 001210-19, 001566-19, 002622-19, 003065-19, 003377-19, 004116-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 27, 2019
Licensee / Titulaire de permis :	The Corporation of the County of Lanark c/o Lanark Lodge, 115 Christie Lake Road, PERTH, ON, K7H-3C6
LTC Home / Foyer de SLD :	Lanark Lodge 115 Christie Lake Road, R. R. #4, Lot 27, Concession 2, PERTH, ON, K7H-3C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennie Bingley

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To The Corporation of the County of Lanark, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_765541_0019, CO #001;

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 be compliant with O. Reg. 79/10, s. 15 (1). Specifically the licensee shall:

1) Ensure that bed rail use for resident #015, #016 and #017, and any other resident, is assessed and implemented in full accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) (FDA clinical guidance document). This includes, but is not limited to:

a) A documented individual resident assessment conducted by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment conducted by the interdisciplinary

team, considering all of the information gathered during the individual resident assessment. The documented risk benefit assessment, as per the FDA clinical guidance document, is to include:

i) Identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident;

ii) Comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. Consideration of the potential for injury or death with the use of bed rails must include consideration of the risk of entrapment, as outlined in the "Guiding Principles" section of the FDA clinical guidance document.

iii) A final conclusion, if bed rails are used, indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

c) Approval of the use of bed rails for an individual resident by the interdisciplinary team members that conducted the assessment process and made the final decision. The names of the team members, and the rationale, is to be clearly documented.

2. Inspect all residents' bed systems with bed helpers (BH) in place to verify that the BH is flush with the side of the mattress. If not, conduct entrapment zone testing as prescribed by the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document). Take immediate corrective actions in response to entrapment zone testing failures.

3. Ensure all staff are aware of the need to report a change to the fixed position of a bed helper, as was observed on resident #013's bed, to the maintenance department.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order (CO) #001 from

Complaint Inspection #2018_765541_0019. The CO report date was January 2, 2019, and the CO originally had a compliance due date (CDD) of March 1, 2019. The CDD was subsequently extended, upon request from the licensee. The final CDD was May 15, 2019.

The licensee was ordered to comply with O. Reg. 79/10, s. 15 (1), and, to specifically comply with the following items:

1) Ensure that bed rail use for resident #001, #002, #006 and any other resident is assessed and implemented in full accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) (FDA clinical guidance document). This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment, following the resident assessment by the interdisciplinary team, where bed rails are in use. The documented risk benefit assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion, if bed rails are used, indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

2) Ensure that steps are taken and documented to prevent resident entrapment for residents #001, #002, #006 and any other resident, taking into consideration all potential zones of entrapment.

The licensee failed to complete step 1 in that bed rail use was not assessed in accordance with the FDA clinical guidance document.

The licensee completed step 2 in that the "M-Rail home bed assist handles" were removed from all residents' bed systems.

In relation to evidence based and prevailing practices:

In August, 2012, the Ministry of Health and Long-Term Care (MOHLTC) issued a memo to all Long-Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

The HC guidance document includes the titles of two additional companion documents. The referenced companion documents are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is a clinical practice guideline, titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used. The other companion document is titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006, FDA".

On March 27, 2019, the MOHLTC issued another memo to the Long-Term Care Home sector about the use of bed rails in long term care homes. The memo included reference and links to the three documents noted above, as well as a summary of expectations related to assessing residents and evaluating bed systems.

Related to the evaluation of residents' bed systems, where bed rails are used, in accordance with evidence-based practices to minimize risk to the residents:

It is noted that with one exception, the type of bed rails in use in the home at the time of the inspection are referenced by the home as bed helpers (a.k.a pivot assist devices). Entrapment zones 1, 2, 3 and 4 exist with this type of bed rail and as such bed system evaluation remains a requirement, including testing of the above referenced entrapment zones.

On May 31, 2019, Inspector #133 observed resident #013's bed system. There was a bed helper (BH) on the right side of the bed, and there was a gap of approximately 3.5 inches between the side of the mattress and the BH (entrapment zone 3). This was in contrast to other observed bed systems with a BH, where the BH was typically flush with the side of the mattress. On June 6, 2019, maintenance worker #115 conducted entrapment zone testing on resident #013's BH and it was determined that zone 3 failed. Maintenance worker (MW) #115 noted that the mattress on the bed was highly compressible (Pressure Pedic). Later that day, on June 6, 2019, a firmer mattress (Geo Matt) was put into place for resident # 013. Entrapment zone testing was documented by MW #115, and zone 3 was noted to have passed. On June 7, 2019, in resident #013's bedroom, MW #116 indicated that BHs are always installed so they are flush with the side of the mattress, however, it is possible to move a BH out and away by manipulating the BH hardware under the bed. Inspector #133 observed MW #116 conduct entrapment zone testing on resident #013's BH. The testing was done with the BH flush with the side of the new mattress, and, with the BH out and away from the side of the new mattress as it had been on June 6, 2019. Entrapment zone 3 passed in both scenarios. It was concluded by MW #116 that the combination of the highly compressible nature of the Pressure Pedic mattress and the gap between the BH and the side of the

Pressure Pedic mattress had resulted in the zone 3 failure observed the previous day. It was determined that entrapment zone testing had been conducted, with the Pressure Pedic mattress and the BH fixed into position flush with the side of the mattress, and all zones had passed. It could not be determined who had moved the BH out and away from the side of the Pressure Pedic mattress, or when. It was determined that the change had not been communicated to the maintenance department, and therefore entrapment zone testing had not been conducted.

In summary; resident #013's bed system was not evaluated in accordance with evidence based practices, to minimize risk to the resident, following a change to the fixed position of the bed helper in relation to the side of the mattress.

Related to the assessment of residents, where bed rails are used, in accordance with prevailing practices to minimize risks to the residents:

As per the FDA clinical guidance document: Decisions to use or discontinue use of bed rails is to be made in the context of an individual resident assessment by an interdisciplinary team with input from the resident and family or the resident's legal representative. The factors to be included in the resident assessment are prescribed. Considering the information gathered, the team is then to complete a risk benefit assessment (as prescribed). The use of bed rails is to be based on the resident's assessed medical needs, documented clearly and approved by the interdisciplinary team. If clinical and environmental interventions have proven unsuccessful in meeting the residents assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used.

On June 3, 2019, Inspector #133 observed a BH in place on the right side of resident #014's bed. The resident's electronic health care record, and paper chart, were reviewed. The use of the BH was referenced in the resident's care plan. A Bed Rail Risk Assessment– V2 (BRRA) could not be located. Resident #014's admission checklist had been completed by Registered Practical Nurse (RPN) #117 on a specified date. On June 4, 2019, RPN #117 indicated that they had not been aware that a BH had been in use for resident #014. RPN #117 indicated that they had not completed a BRRA upon the resident's admission.

RPN #117 indicated that if a BRRA had been completed for resident #014, by anyone, it would be part of the electronic health care record. A BRRA was subsequently completed for the resident that day, by RPN #118. It was noted in the BRRA that a BH was in place when resident #014 had moved into their bedroom. As per the BRRA, and based on resident #014's identified risk factors, the decision was made to remove the BH from the resident's bed for safety purposes.

In summary, bed rail use was implemented for resident #014 in the absence of an assessment process as per the FDA clinical guidance document.

In relation to the overall assessment and decision making process in place related to bed rail use, Inspector #133 interviewed the Director of Care on June 4, 2019. Over the course of the interview, it was established that the assessment and decision making process about bed rail use was not conducted by an interdisciplinary team, it was conducted by registered nursing staff. It was established that an interdisciplinary team had been involved in the creation of the home's Bed Rail Risk Assessment – V2 (BRRA). In this way, the DOC explained, it was thought that the requirement for an interdisciplinary team approach had been satisfied. The DOC indicated that the interdisciplinary team did not reference the Compliance Order or the FDA clinical guidance document when creating the BRRA. It was noted that the BRRA did not include all specified factors as per the Compliance Order and as per the FDA clinical guidance document, such as: sleep habits; medication; communication; ability to toilet self safely; risk of falling.

On June 4, 2019, Inspector #133 interviewed Registered Practical Nurse (RPN) #117 about the BRRA that they had completed for resident #015 on March 14, 2019. The RPN indicated that it is the registered nursing staff that complete the questions on the BRAA and make a decision about bed rail use for a resident. The RPN indicated that they had completed the BRRA, with information from Personal Support Workers (PSWs). The RPN indicated that there was no team in place to consider the results of the BRRA and to make decisions. The Inspector referenced the specified factors for a resident assessment, as per the Compliance Order and the FDA clinical guidance document, to verify if some factors may have considered in the absence of a specifically related question on the BRRA. The RPN indicated they would not have considered the following

factors: sleep habits; medications; ability to toilet self safely; and communication.

On June 5, 2019, while off site, Inspector #133 interviewed RPN #119 on the telephone about the BRRA that they had completed for resident #016 on March 15, 2019. The RPN indicated that the PSWs that provided daily care to the resident felt that the resident would benefit from a BH. The RPN indicated that they recalled a nursing co-worker had looked at the questions with them, as the RPN had not yet completed a BRRA. RPN #119 indicated that they answered the questions and came to a final conclusion that a bed helper would be of benefit for the resident. The RPN indicated that there was no established team to do the assessment and to make a final decision. The RPN indicated they would not have considered the following factors: sleep habits; medications; ability to toilet self safely; communication; risk of falling.

On June 6, 2019, Inspector #133 interviewed RPN #120 about the BRRA that they had completed for resident #017 on March 15, 2019. The RPN indicated that there was a bed helper (BH) in place for the resident at the time that they completed the BRRA. The RPN indicated that there was no interdisciplinary team in place to consider the information in the BRRA. The RPN indicated that they knew resident #017 well and could answer the questions on their own when completing the BRRA. The RPN indicated that for a new resident, they would talk to others to gather any information they needed to answer the questions and to come to a conclusion. The RPN indicated they would not have considered the following factors: sleep habits; medications; ability to toilet self safely; communication; risk of falling. It was noted that the RPN had answered "Yes" to question A5 "Does the resident attempt to get out of bed unsupervised?". If answered Yes, it is indicated "consider entrapment issues & alternatives". The RPN explained to the Inspector that they thought that answering yes to this question would be indicative of a need for a BH, rather than informing about risk of entrapment.

In summary, the home's assessment and decision making process regarding bed rail use was not in accordance with the prevailing practices outlined in the FDA clinical guidance document. Where bed rails are used, residents have not been assessed in accordance with prevailing practices, to minimize risk to the resident.

In conclusion, the decision to reissue this compliance order was based on the following:

The severity of the non-compliance was such that there was actual risk of harm to resident #013 and #014, in relation to their bed systems. There was actual risk of harm to resident #015, #016, #017, and all other residents with bed rails in use, in relation to the assessment and decision making process.

The scope of the non-compliance identified was widespread, in that the bed rail use assessment and decision making process in place was not in accordance with prevailing practices, as per the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, FDA, 2003"

Related to the licensee's compliance history, the Compliance Order (CO) is reissued to the same section and subsection, O. Reg. 79/10, s. 15 (1), related to bed rail use. CO #001 was served to the licensee in January 2019 as a result of Complaint Inspection #2018_765541_0019. The licensee has not been issued any additional COs within the last 36 months.

(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 27, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Megan MacPhail

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