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
Apr 15, 2019	2019_745690_0006	002515-19, 003703-19, 003958-19, 004208-19, 004670-19, 005225-19, 005798-19	Critical Incident System

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 Kelly Drive GRAVENHURST ON P1P 1P3

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

TRACY MUCHMAKER (690), MICHELLE BERARDI (679)

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): April 1-5, 2019.

The Following intakes were inspected upon during this Critical Incident Inspection:
-Two logs were related to critical incidents the home submitted to the Director regarding an injury that resulted in a transfer to hospital;and,
-Five logs were related to critical incidents the home submitted to the Director regarding alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Maintenance Worker (MW), Activation Aide (AA), Personal Support Workers (PSW), residents and family members.

During the course of the inspection, the inspector(s) conducted observations in resident home areas, observation of care delivery processes, review of the home's policies and procedures, review of the home's internal investigation notes, and residents' health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **2 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 ensure that where bed rails were used, the resident was assessed and that the residents' bed systems were evaluated in accordance with prevailing practices to minimize risk to the resident.

A Critical Incident (CI) report was submitted to the Director on an identified date, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified that resident #001 sustained an injury involving their bed system.

On August 21, 2012, a notice was issued to the Long Term Care Home (LTC) Administrators from the Director of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, identifying a document produced by Health Canada entitled "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 and provided clear procedures and dimensional criteria with respect to evaluating bed systems using a cone and cylinder tool. The Health Canada Guidance (HCG) document also included the title of a companion guide developed by the Food and Drug Administration (FDA) in the United States entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006" The guide included information with respect to the various options and corrective strategies available to mitigate entrapment zones, a guide to buying beds, how to inventory bed systems and reviews the dimensional criteria of bed systems. The documents were considered prevailing practices, which were predominant, generally accepted widespread practice as the basis for clinical decisions with respect to

bed safety.

Inspector #690 requested a copy of the most recent evaluation of the bed systems in the home. The Administrator provided the Inspector with an identified document. The document included information on the room number that the bed was in, a bed number to identify the bed, serial number of the bed, rail issues, the rail type, type of bed frame, mattress number, mattress type, entrapment zones one to seven, if the bed had mattress keepers, a column to list any failures and follow up actions to correct the failure. The Administrator indicated that this document was completed during the annual testing of beds that last took place in May 2018, and that all bed evaluations were completed by the maintenance staff in the home. The Administrator additionally indicated that if there had been any bed entrapment evaluations on a bed since the annual inspection, due to a change in equipment or a new admission, it would be captured through the home's maintenance care program. The Administrator further indicated that the maintenance care records would indicate that all entrapment zones were checked and considered safe.

A review of the identified document indicated that all beds identified on the sheet had passed entrapment zones one through seven. The columns for identifying a reason for any failures and follow up actions did not indicate any bed rails that failed any entrapment zones or any corrective actions made to the bed, such as tightening of bed rails, or the addition of any accessories to any beds. Under the column titled "Rail Issues", the information indicated either "no rails, or "single rails". It was not clear to the Inspector if that indicated that beds either had no bed rails or had only a single bed rail on the bed. The document indicated that there were two beds that had air mattresses and one bed that had a Roho mattress. It was suspected that the maintenance staff completing the bed evaluations did not follow the procedures identified in the HCG document for bed evaluations.

Inspector #690 reviewed the home's policy titled "Bed Safety Program Overview #VII-E-10.18(a)" dated April 2018. The policy indicated that the home would institute a spreadsheet for all beds in the home to note testing dates, outcomes of the entrapment assessments, and corrective actions to fix deficiencies found during the inspection.

Inspector #690 and #679 conducted an observation of bed systems in the home and noted the following:

-A bed in an identified room had an identified mattress, a type of mattress with soft air

filled cells in the middle section of the bed. There were two quarter length rotating assist bed rails on either side of the bed, the bed rail closest to the window was in the guard (horizontal) position and the bed rail closest to the door was in the assist (vertical) position. There were two metal mattress keepers on the bed and the mattress was sitting on top of the mattress keepers which allowed the mattress to slide away from the bed rail, which created a gap between the mattress and the bed rail.

-A bed in an identified room had an identified mattress. There were two quarter length, rotating assist bed rails on either side of the bed, both bed rails were in the guard position. There were four plastic mattress keepers on the bed. The mattress was sitting on top of the mattress keepers at the foot of the bed, which caused the mattress to slide away from the bed rail, which created a large gap between the mattress and bed rail. Both bed rails on the bed were loose.

-A bed in an identified room had an identified mattress, a type of mattress with soft air filled cells along the entire length of the mattress. There was one quarter length bed rail on the side of the bed closest to the window. There were four plastic corner keepers on the bed. The mattress was sitting on top of the mattress keepers which caused the mattress to slide away from the bed rail, which created a large gap between the mattress and bed rail. Both bed rails on the bed were loose.

- A bed in an identified room had an identified mattress, two rotating assist bed rails, one on either side of the bed. The bed rail closest to the window was in the assist position, and the rail closest to the door was in the guard position. Both bed rails were loose, there was a large gap between the mattress and the bed rail on both sides.

-In addition, Inspectors #690 and #679 noted the following beds in eight identified rooms that had only one quarter length rotating assist bed rail on the bed. The mattresses were sitting on top of the mattress keepers, which caused the mattress to slide away from the bed rail and created a gap between the mattress and the bed rail. These beds were documented as passing all zones on the bed entrapment inspection sheet.

Inspector #690 requested maintenance care records for bed entrapment evaluations that were completed after the annual inspection that took place in May 2018, for six identified beds and noted that on many of the maintenance care records, it was indicated that bed entrapment was completed and was "okay". The records did not indicate which entrapment zones were tested or if there were any corrections made to the bed or if there were any entrapment zone failures. The Director of Care indicated that if the

maintenance care records indicated that the bed entrapment was completed or okay, then it indicated that the bed passed all entrapment zones.

Inspectors #690 and #679 and the Director of Care (DOC) observed Maintenance worker (MW) #117, who acknowledged that they were one of the staff responsible for completing bed evaluations and also trained new employees on the procedure, demonstrate the home's process of bed evaluations. It was noted that maintenance worker #117 did not follow the HCG document for bed evaluations during the demonstration. MW #117 indicated that they did not record the entrapment zones tested and they did not know where each entrapment zones was and that the rotating assist bed rails were not tested in the assist position. During an observation of a bed evaluation in an identified room on a bed that was equipped with a Roho mattress, the bed failed entrapment zone two, as the large end of the cone entered the space between the mattress and bed rail with the rail in both the guard and assist position. A demonstration of the bed evaluation in another identified room by MW #117 indicated that the air mattress failed both zones two and three when tested. An additional demonstration of a bed evaluation in an identified room on a bed that was equipped with only one rotating assist bed rail was conducted. It was noted and pointed out to MW #117 and the DOC that the mattress was sitting on top of the mattress keepers and would slide away from the mattress and the entrapment evaluation could not be properly completed. The DOC acknowledged that all beds with only one rail, that had mattresses sitting on top of the mattress keepers would not pass the entrapment evaluation.The DOC further indicated that the home's current bed entrapment inspection sheet did not indicate which beds have only one rail as many of the beds on the inspection sheet were documented as having a "single rail", had two bed rails on the bed.

In an interview with Inspector #690, the DOC indicated that all beds in the home would be evaluated yearly, on all new admissions and with any equipment changes made to the mattress or bed. The DOC acknowledged that the Bed Entrapment Inspection Sheet should indicate whether a bed had one or two bed rails, if there were any failures of any zones and what was done to correct the failure. The DOC acknowledged that all beds with only one rail, that had mattresses sitting on top of the mattress keepers would not pass the entrapment evaluation. The DOC further indicated that the beds in the home had not been evaluated according to the HCG document and that they should have been.

In an interview with Inspector #690, the Administrator indicated that maintenance worker #117 last had training when the home purchased the tool several years ago. The

Administrator further indicated that the beds had not been evaluated according to the HCG document, and that all maintenance workers would have to be re-educated on the correct process in order for the beds to be evaluated according to the HCG document.

2. The licensee's bed rail use clinical assessment form and process was reviewed by Inspector #690, and it was determined that it was not fully developed in accordance with the Clinical Guidance document identified in the above mentioned notice issued to Long-Term Care Home Administrators. The companion documents referenced in the notice 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 were made that where bed rails are used for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing risks and implemented where necessary. The assessment guideline offers example key assessment questions that guides decision-making such as the resident's history of falls from bed, previous bed rail use, communication limitations, their mobility, cognitive status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors and the entrapment status of the resident's bed.

The guidance document also emphasizes the need to document clearly whether alternatives to bed rails were used, and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or the SDM and any other interdisciplinary team members, would be made about the necessity and safety of the bed rail use for a particular resident and details documented on a form (electronically or paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the resident or the SDM), the size or type of the bed rail to be applied (rotating assist, fixed assist, 1/4, 1/2, 3/4 bed rail), when the bed rails are to be applied, how many bed rails, on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

A review of the home's policy by Inspector #690, titled "Bed Rail Safety Guidelines V-II-10.20 (a)" dated April 2018 indicated that if bed rails were used, staff would conduct an individualized assessment that should include consideration into; medical diagnosis, conditions, symptoms, behavioural symptoms,exsistence of delirium, sleep habits,

medication, acute medical or surgical interventions, ability to toilet self, cognition, communication, mobility and risk of falling. The policy further indicated that the sleep environment would be assessed and include consideration into pain, comfort, hydration, temperature of the room, lighting, sleep regimes, toileting patterns and bed mobility. A review of an additional policy titled "Bed Rails VII-E-10.20", last revised May 2017, indicated that a quarterly assessment of bed rails would be done for a resident's use or removal of bed rails.

A) Resident #001's bed was observed on an identified date by Inspector #690 to have a specified bed rail configuration.

Inspector #690 reviewed the above mentioned CI report and conducted a review of resident #001's electronic health records, which identified a document titled "Bed safety assessment V2". The bed safety assessment had been initiated on an identified date and completed 42 days later, on the day of the incident mentioned in the CI report. The assessment indicated that bed rails were not required and were not indicated for resident #001. The assessment included a reference to the incident that the CI report was submitted to the Director for, and that resident #001's SDM consented to the bed rails being removed from the bed. A further review of electronic health records identified a bed safety assessment that was initiated on an identified date, that was not completed until approximately 14 weeks later. The assessment identified that resident #001 required a specified level of assistance by staff for identified activities of daily living (ADL) and that bed rails were not required for resident #001. The assessment indicated that bed rails were contraindicated for resident #001 as a result of the outcome of the sleep evaluation, but that bed rails would be used, and resident #001 had a specified bed rail configuration to be used at specified times. The assessment further indicated that alternatives to the bed rails were not tried. The bed safety assessment did include a component related to evaluating the resident's sleep pattern, habits and behaviours while sleeping in bed, movement patterns, cognitive status, a history of falling from bed, and a history of restlessness. The assessment did not include consideration into medication use, medical diagnosis, toileting patterns or pain with or without the application of the bed rails. Additionally, the assessment did not include information on the type of bed rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on. Although the assessment included information on whether the resident or SDM requested the bed rails and that they were made aware of the risk factors associated with bed rail use, the assessment did not include information about the alternatives to bed rails being discussed with the resident or SDM.

In an interview with Inspector #690, resident #001's SDM indicated that they had requested the bed rails on the bed as resident #001 would use the bed rails to assist with a specified ADL. They went on to state that they had been made aware of the risk factors of having the bed rails in place. The SDM indicated that resident #001 had the specified bed rail configuration at the time of the incident on the identified date. The SDM indicated that they witnessed resident #001's incident related to their bed system. The SDM further indicated that they were not informed of what alternatives could be used in place of the bed rails.

In an interview with Inspector #690, Personal Support Worker (PSW) #119 indicated that at the time of the incident, resident #001 had a specified bed rail configuration on the bed. PSW #119 indicated that they had found resident #001 at the time of the incident. PSW #119 indicated that at the time of the incident, resident #001 was not capable of using the bed rails to assist with a specified ADL, that resident #001 required a specified level of assistance by staff to perform the ADL, and they were unsure why the bed rails were in place. PSW #119 indicated that they participated in the assessment of the use of bed rails by completing a sleep observation during the night shift. PSW #119 indicated that they would observe residents and answer a series of questions under the support actions on Point of Care (POC). PSW #119 further indicated that the sleep observation did include observing the movement patterns of a resident and whether the call bell was within reach, but that the observation did not include observing a resident's toileting patterns, the presence of pain, or any communication issues related to the safe use of bed rails.

In an interview with Inspector #690, Registered Nurse (RN) #111 indicated that they were working when the incident mentioned in the CI report occurred, and were called to resident #001's room by PSW #119. They indicated that they observed the incident with resident #001 involving their bed system. RN #111 indicated that resident #001 sustained injuries from the incident and that they sent resident #001 to the hospital. RN #111 indicated that resident #001 was not capable of using bed rails for performing a specified ADL at the time of the incident and could not recall the bed rail configuration at the time of the incident. RN #111 indicated that they did not participate in the bed safety assessments of residents, and the assessments were completed by Registered staff on days.

In an interview with Inspector #690, Registered Practical Nurse (RPN) #120, who was also one of the Resident Assessment Instrument (RAI) Coordinators for the home, indicated they were responsible for completing bed safety assessments on residents to

determine if a resident was safe to have bed rails. RPN #120 indicated that assessments were to be completed on a quarterly basis and when there was a change in a residents status. RPN #120 further indicated that the assessment should be completed within 14 days of being initiated. RPN #120 indicated that resident #001 was not capable of utilizing the bed rails at the time of the incident, and that according to the bed safety assessment, bed rail use was contraindicated for resident #001; however the SDM for resident #001 requested the rails remain in place. Together Inspector #690 and RPN #120 reviewed the last three bed safety assessments for resident #001, and RPN #120 indicated that resident #001's assessments did not include information on the type of bed rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on, a component related to consideration into medication use, medical diagnosis, toileting patterns or pain. RPN #120 further indicated that resident #001's bed safety assessment did not include a component to indicate that alternatives to bed rails had been attempted and, the effectiveness of the alternative or that the assessment had information on the type of rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on. They indicted that although the assessment included information on whether the SDM requested the bed rails, the assessment did not include a component to indicate that alternatives to bed rails were discussed with the SDM. They also indicated that the assessments were not completed on a quarterly basis and that they should have been.

B) Resident #008's bed was observed to have a specified bed rail configuration. The bed rails were both in a specified position and the resident was in bed at the time of the observation. The bed was in an identified position, there were three additional identified falls prevention devices present.

Inspector #690 reviewed health records for resident #008 and identified a bed safety assessment was initiated on an identified date and completed 27 days later. The bed rail assessment indicated that the bed rails were in place due to request by resident #008's SDM. The bed safety assessment for resident #008 indicated that resident #008 was not capable of using the bed rails and that bed rails were contraindicated. The bed safety assessment did not include a component related to consideration into medication use, medical diagnosis, toileting patterns or pain with or without the application of the bed rails. The assessment did not include information on the type of bed rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on.The bed safety assessment further did not include a component to indicate that alternatives to bed rails had been attempted and the effectiveness of the alternative. Although the assessment included information on whether the SDM requested the bed rails, the assessment did not include a component to indicate that alternatives to bed rails were discussed with the

SDM.

In an interview with Inspector #690, PSW #118 indicated that resident #008 had a specified bed rail configuration. PSW #118 indicated that resident #008 was not capable of using the bed rails for an identified ADL, that they used to be at risk of falling from bed, but was no longer at risk of falling. They further indicated that resident #008 had always had the bed rails, and they had never observed them without the bed rails.

In an interview with RPN #120, they indicated that resident #008 had a specified bed rail configuration on their bed and that resident #008 was not capable of using them for an identified ADL. They further indicated that the only reason resident #008 had the bed rails was because of a request. RPN #120 indicated that resident #008's bed safety assessment from the identified date, was not completed within the required time frame, on a quarterly basis and that it did not include information on the type of bed rail (rotating assist, or fixed assist), and what side of the bed the bed rails were to be on, and a component related to consideration into medication use, medical diagnosis, toileting patterns or pain. RPN #120 further indicated that resident #008's bed safety assessment did not include a component to indicate that alternatives to bed rails had been attempted and the effectiveness of the alternative or that the assessment had information on the type of rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on. They indicted that although the assessment included information on whether the SDM requested the bed rails, the assessment did not include a component to indicate that alternatives to bed rails were discussed with the SDM.

C) Resident #009 was observed to have a specified bed rail configuration. The resident was in bed at the time of the observation. The bed was in an identified position, there were three additional identified falls prevention devices in place.

Inspector #692 reviewed health records for resident #009 and identified a bed safety assessment from an identified date. The bed safety assessment indicated that bed rails were in place at the request of the residents SDM and that bed rails were contraindicated for resident #009. The bed safety assessments did not include a component related to consideration into medication use, medical diagnosis, toileting patterns or pain with or without the application of the bed rails. The bed rail risk assessment did not include a component to indicate that alternatives to bed rails had been attempted and the effectiveness of the alternative. The assessment did not include information on the type of bed rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on.

In an interview with Inspector #690, PSW #118 indicated that they did participate in the bed rail assessment of residents and document on their movement patterns, whether the call bell was within reach, if the resident was observed on the left or the right side of the bed and if the resident had an undisturbed sleep. They did not observe or document on toileting habits, continence, or pain related to the use of bed rails. PSW #118 indicated that resident #009 had a specified bed rail configuration on their bed. PSW #118 indicated that resident #009 was not capable of using the bed rails for an identified ADL and required a specified level of assistance by staff for the identified ADL.

In a interview with Inspector #690, RPN #110 indicated that resident #009 no longer used their bed rails for the identified ADL, that there was a change in their health status and that the only reason that resident #009 had the bed rails was due to a request.

In an interview with Inspector #690, Nurse Manager (NM) #102, indicated that they were responsible for completing the bed rail risk assessments for residents upon admission, with any change in the resident's bed system or a significant change in a resident's status and on a quarterly basis. NM #102 indicated that the assessment did not include consideration into medication use, medical diagnosis, toileting patterns or pain with or without the application of the bed rails. NM #102 further indicated that alternatives to bed rails were not attempted prior to the application of bed rails for resident #001, #008 or #009. Additionally NM #102 indicated that the assessments were to be completed on a quarterly basis and that assessments for resident #001 and #008 were not completed on a quarterly basis and that they should have been.

In an interview with Inspector #690, the DOC indicated that they were aware of the HCG documents, and what was included in the documents related to the clinical assessment of the resident regarding the use of bed rails. The DOC indicated that the home's process for assessing the risk versus benefit use of the bed rails did not include medical diagnosis, behaviours, medication use pain or toileting patterns with or without the use of bed rails. The DOC also identified that the home did not attempt alternatives to the use of bed rails for resident #001, #008, and #009 prior to the application of the bed rails and that the home's process for completing the bed rail risk assessment was not done in accordance with the current prevailing practices for all residents. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to from friendships and relationships and to participate in the life of the long term care home.

Three CI reports were submitted to the Director for incidents of alleged resident to resident abuse. The CI reports indicated that residents were found exhibiting responsive behaviours towards each other. The CI reports further identified that the residents were immediately separated and assessed after their interactions.

Inspector #679 reviewed the electronic progress notes for residents #005 and #006 and identified that the residents were interacting with each other on approximately 15 occasions over a two month period. The progress notes identified that each time the interaction was documented the residents were separated.

Inspector #679 reviewed resident #005's current electronic care plan which identified a focus for an identified responsive behaviour. The interventions outlined in the care plan identified that staff were to re-direct/separate the residents.

Inspector #679 reviewed resident #006's electronic care plan which identified a focus for an identified responsive behaviour that indicated that resident #006 exhibited specified responsive behaviours. The interventions outlined in the care plan identified that staff were to "Re-direct/re-focus resident when triggers to responsive expressions are

demonstrated" and included other interventions listed.

A review of a specific policy was conducted.

In an interview with PSW #104, they identified that resident #005 would interact with resident #006. PSW #104 identified that neither of the residents had seemed upset about their interactions with each other. PSW #104 identified that at the time of the incidents the home's staff were separating the residents.

In an interview with PSW #103, they identified that had observed resident #005 and #006 interacting with each other. PSW #103 identified that resident #005 would seek out resident #006. PSW #103 further identified that staff would try and side track them, or bring resident #006 to another part of the unit. PSW #103 identified that this wasn't always effective and sometimes the staff would have to try this "a few times".

In an interview with RPN #105, they identified that resident #005 would seek out resident #006. RPN #105 identified that staff were told to separate them; however, the re-direction was not always effective and they would continue to seek each other out.

In an interview with RN #107, they identified that staff were separating residents #005 and #006. RN #107 identified that this was not effective, and the residents would find their way back together.

In an interview with the DOC, they identified that resident #005 and #006 would interact with each other. The DOC reviewed the electronic incident notes and identified that the residents were found on each occasion to be interacting with each other, and that the residents were separated. Inspector #679 asked the DOC how the home was respecting the residents rights to build a relationship, to which the DOC acknowledged that at the times of the incident, they "probably weren't", but that the home has worked on changing this. [s. 3. (1) 18.]

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 every resident has the right to form friendships and relationships and to participate in the life of the long term care home, to be implemented voluntarily.

WN #3: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A) A CI report was submitted to the Director for an incident of resident to resident physical abuse. The CI report identified that resident #002 was observed to have exhibited an identified responsive behaviour towards resident #003 and that resident #003 was upset regarding the incident.

A review of resident #002's electronic progress notes by Inspector #679 identified a specific type of assessment document was initiated for resident #002 after the incident on an identified date. The specific assessment indicated that staff were to complete the assessment documentation every half hour.

Inspector #679 reviewed resident #002's specific assessment document record for the period of seven days, and identified missing documentation on several days.

In an interview with PSW #106, they identified that if a resident was being assessed by

the specific assessment document it was to be documented every half hour. Together, Inspector #679 and PSW #106 reviewed resident #002's specific assessment document record, and PSW #106 confirmed that the documentation should have been completed every half hour.

B) Three CI reports were submitted to the Director for incidents of resident to resident abuse. The CI reports identified that residents #005 and #006 were found exhibiting identified responsive behaviours towards each other.

A review of resident #005's electronic progress notes by Inspector #679 identified that a specific assessment document was in place for resident #005 after the incident on an identified date.

Inspector #679 reviewed resident #005's specific assessment document record for the period of seven days, and identified missing documentation on several days.

A review of resident #006's electronic progress notes by Inspector #679 identified that a specific assessment document was in place for resident #006 after an incident on an identified date.

Inspector #679 reviewed resident #006's specific assessment document record for the period of seven days, and identified missing documentation on several days.

In an interview with PSW #113 they identified that residents #005 and #006 were started on a specific assessment document after their incidents together. PSW #113 identified that the specific assessment document record would be completed at the interval outlined on the record. Together, Inspector #679 and PSW #113 reviewed the specific assessment document record and PSW #113 confirmed the documentation should be completed.

A review of the policy titled "Documentation- Resident Record (VII-J-10.00)" last revised January 2015, identified that PSWs were to record electronically, or on hard copy all pertinent resident care delivery information prior to the end of their shift on the resident's individual record.

In an interview with Inspector #679, RN #107 identified that a specific assessment document record would be implemented after an incident to monitor the resident and to determine any trends, or possible triggers which could lead to a resident exhibiting

responsive behaviours. Together, Inspector#679 and RN #107 reviewed the specific assessment document record, and RN #107 confirmed that the documentation should have been completed.

In an interview with NM #102, they identified that a specific assessment document record would be initiated for a resident upon admission, and if a resident was exhibiting new or worsening behaviours. Together, NM#102 and Inspector #679 reviewed the specific assessment document records for residents #002, #005 and #006, and NM #102 identified that it was their expectation that the documentation was fully completed.

Together, Inspector#679 and the DOC reviewed the specific assessment document records for residents #002, #005 and #006. The DOC identified that the documentation should have been completed every 30 minutes. [s. 6. (9) 1.]

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 the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessment, reassessment and interventions and that the resident's responses to interventions were documented.

A CI report was submitted to the Director for an incident of resident to resident physical abuse. The CI report identified that resident #002 was observed to have exhibited an identified responsive behaviour towards resident #003 and that resident #003 was upset regarding the incident.

A review of resident #002's electronic progress notes by Inspector #679 identified that on an identified date, resident #002 was observed exhibiting an identified responsive behaviour towards resident #010.

The progress note further identified that resident #002 was redirected back to their room, but that a few minutes later a visitor had observed resident #002 exhibit an identified responsive behaviour towards resident #003.

A further review of the electronic progress notes identified that resident #002 was involved in approximately 20 incidents of responsive behaviours towards co-residents over the period of three months.

Inspector #679 reviewed resident #002's current electronic care plan and identified the focus for an identified responsive behaviour. The care plan identified specified interventions to manage the identified responsive behaviour.

Inspector #679 reviewed resident #002's care plan from the previous quarter and identified that the focus, and the interventions matched the current care plan, with the exception one specified intervention that was implemented during the three month period.

In separate interviews with Inspector #679, PSWs #106 and #112 identified that resident #002 exhibited identified responsive behaviours. PSW #106 and #112 identified that if the interventions outlined in the plan of care were not effective for managing the residents behaviours, they would report this to the registered staff.

In an interview with Inspector #679, RPN #110 identified that resident #002 exhibited responsive behaviours. RPN #110 identified that interventions to manage responsive behaviours would be re-assessed when they were not effective, and that it was "hard to say if [resident #002's] interventions were effective".

In an interview with RPN #116 they identified that resident #002 exhibited responsive behaviours. RPN #116 identified that there were interventions outlined in the care plan to manage the responsive behaviours, but that the interventions including the intervention that was implemented during the three month period were not effective.

In an interview with NM #102, they identified that resident #002 exhibited identified responsive behaviours. NM #102 reviewed the care plan and identified that there were interventions in place to manage the behaviours, and identified that the interventions could be effective; however, when resident #002 was fixated it was hard to re-direct them. NM #102 identified that interventions regarding responsive behaviours should be re-assessed at least quarterly, and that they didn't think the responsive behaviour interventions were re-assessed for resident #002.

Together, the Inspector and the DOC reviewed the current, and historical care plan and identified that resident #002 exhibited identified responsive behaviours, and that there were interventions in the care plan to manage the behaviours. Inspector #679 questioned if the home had re-assessed the residents responsive behaviour interventions, to which the DOC responded that the one intervention that was implemented in the three month period was more of an intervention for a co-resident. The DOC identified that they were not aware of any other interventions that were trialed. [s. 53. (4) (c)]

2. A CI report was submitted to the Director for an incident of resident to resident abuse that occurred on an identified date. The CI report identified that resident #007 was observed to be exhibiting a responsive behaviour towards resident #011 and that resident #011 was visibly upset. Resident #011 was found to have sustained an injury from the incident.

A further review of the electronic progress notes identified that resident #007 had five incidents of responsive behaviours towards co-residents over a three month period, including an incident that occurred between resident #007 and resident #011 on the day after the incident for which the CI report was submitted for. The progress note indicated that resident #011 was observed to exhibit a responsive behaviour towards resident #011. Staff re-directed resident #011 away from resident #007.

Inspector #690 reviewed resident #007's current electronic care plan and identified the focus for an identified responsive behaviour. The care plan identified specified support actions to manage the identified responsive behaviour.

Inspector #690 reviewed resident #007's previous care plan and identified that the focus, and the interventions matched the current care plan, and that there had been no new interventions or changes to the care plan interventions related to responsive behaviours.

In separate interviews with Inspector #690, PSWs #113 and #121 identified that resident #007 exhibited on-going identified responsive behaviours towards co-residents. PSW #113 and #121 indicated that they would access the care plan to find information on a residents responsive behaviours and for interventions on how to manage the responsive behaviours. They further indicated that the current interventions identified on resident #007's care plan were not effective.

In an interview with Inspector #690, RPN #116 identified that resident #007 continued to exhibit identified responsive behaviours towards co-residents and that the identified interventions on resident #007's care plan were no longer effective. RPN # 116 identified that resident #007 had been referred to an external support service in the past and that they had been discharged from the service. RPN #116 further identified that interventions to manage responsive behaviours would be re-assessed when they were not effective, and that the care plan would be revised. They further indicated that there had been no new interventions or any re-referrals to any external support services despite on-going incidents of the identified responsive behaviours.

In an interview with NM #102, they identified that resident #007 exhibited identified responsive behaviours. Together NM #102 and Inspector #690 reviewed the care plan interventions that were in place to manage the resident #007's identified responsive behaviours. NM #102 indicated that the interventions had not been effective and had not been reassessed despite on-going incidents of the identified responsive behaviour towards co-residents. NM #102 further indicated that interventions regarding responsive behaviours should be re-assessed and the care plan revised at least quarterly, and when the interventions were not effective.

In an interview with Inspector #690, the DOC indicated that when a resident's interventions for managing responsive behaviours were not effective, that the resident would be re-assessed and the care plan revised. The DOC indicated that there had been

no new interventions tried with resident #007 or any re-referrals to to external support services despite resident #007 having five episodes of exhibiting the responsive behaviour towards co-residents in a three month period. The DOC indicated that there should have been a re-assessment of resident #007 and the care plan should have been revised. [s. 53. (4) (c)]

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 demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessment, reassessment and interventions and that the responses to interventions are documented, to be implemented voluntarily.

Issued on this 2nd day of May, 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

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

Ministère 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) :	TRACY MUCHMAKER (690), MICHELLE BERARDI (679)
Inspection No. / No de l'inspection :	2019_745690_0006
Log No. / No de registre :	002515-19, 003703-19, 003958-19, 004208-19, 004670-19, 005225-19, 005798-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 15, 2019
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Muskoka Shores Care Community 200 Kelly Drive, GRAVENHURST, ON, P1P-1P3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Coutts

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

Ministère 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

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministère 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

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 must be compliant with s.15(1)(a) of O. Reg. 79/10.

Specifically, the licensee must:

a) Re-evaluate all bed systems in the home using the weighted cone and cylinder tool in accordance with "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. Specifically, the bed systems are to be evaluated for zones 2, 3 and 4, and for beds with rotating assist rails, the bed rails are to be evaluated in both the transfer (vertical position) and in the guard (horizontal) position.
b) Where one or more bed rails will be applied or attached to a bed frame, equip the bed frame with mattress keepers that will keep the mattress from sliding side to side and will allow the mattress to fit properly between the keepers (mattresses must not sit on top of the keepers).
c) Where bed rails do not pass zone 2, 3 or 4, mitigate the bed system in accordance with "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" or equip the bed systems with a different manufacturer's compatible bed mattress or bed rail that passes zones 1 to 4.
d) Educate all bed system evaluators on the requirements of the Health Canada guidelines entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, March 2008" and "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006).
e) Make available the results of the bed system re-evaluation to the interdisciplinary team who participates in assessing each resident for bed rail safety.
f) Keep accurate and detailed records as to the zones that were tested, what was done to a bed once it is initially evaluated (i.e. what specific change was made to the bed, the date the change was made, bed and mattress identifier, who made the changes, the re-evaluation date, auditor name and results).
g) Amend or update policy VII-E-10.30 entitled "Bed Entrapment Prevention" and any other policies related to bed safety to include a reference to "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006) and any additional information and guidance for bed system evaluators for a thorough evaluation.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and that the residents' bed systems were evaluated in accordance with prevailing practices to minimize risk to the resident.

A Critical Incident (CI) report was submitted to the Director on an identified date, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified that resident #001 sustained an injury involving their bed system.

On August 21, 2012, a notice was issued to the Long Term Care Home (LTC) Administrators from the Director of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, identifying a document produced by Health Canada entitled "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 and provided clear procedures and dimensional criteria with respect to evaluating bed systems using a cone and cylinder tool. The Health Canada Guidance (HCG) document also included the title of a companion guide developed by the Food and Drug Administration (FDA) in the United States entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006" The guide included information with respect to the various options and corrective strategies available to mitigate entrapment zones, a guide to buying beds, how to inventory bed systems and reviews the dimensional criteria of bed systems. The documents were considered prevailing practices, which were predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

Inspector #690 requested a copy of the most recent evaluation of the bed systems in the home. The Administrator provided the Inspector with an identified document. The document included information on the room number that the bed was in, a bed number to identify the bed, serial number of the bed, rail issues, the rail type, type of bed frame, mattress number, mattress type, entrapment zones one to seven, if the bed had mattress keepers, a column to list any failures and follow up actions to correct the failure. The Administrator indicated that this document was completed during the annual testing of beds that last took place in May 2018, and that all bed evaluations were completed by the

maintenance staff in the home. The Administrator additionally indicated that if there had been any bed entrapment evaluations on a bed since the annual inspection, due to a change in equipment or a new admission, it would be captured through the home's maintenance care program. The Administrator further indicated that the maintenance care records would indicate that all entrapment zones were checked and considered safe.

A review of the identified document indicated that all beds identified on the sheet had passed entrapment zones one through seven. The columns for identifying a reason for any failures and follow up actions did not indicate any bed rails that failed any entrapment zones or any corrective actions made to the bed, such as tightening of bed rails, or the addition of any accessories to any beds. Under the column titled "Rail Issues", the information indicated either "no rails, or "single rails". It was not clear to the Inspector if that indicated that beds either had no bed rails or had only a single bed rail on the bed. The document indicated that there were two beds that had air mattresses and one bed that had a Roho mattress. It was suspected that the maintenance staff completing the bed evaluations did not follow the procedures identified in the HCG document for bed evaluations.

Inspector #690 reviewed the home's policy titled "Bed Safety Program Overview #VII-E-10.18(a)" dated April 2018. The policy indicated that the home would institute a spreadsheet for all beds in the home to note testing dates, outcomes of the entrapment assessments, and corrective actions to fix deficiencies found during the inspection.

Inspector #690 and #679 conducted an observation of bed systems in the home and noted the following:

-A bed in an identified room had an identified mattress, a type of mattress with soft air filled cells in the middle section of the bed. There were two quarter length rotating assist bed rails on either side of the bed, the bed rail closest to the window was in the guard (horizontal) position and the bed rail closest to the door was in the assist (vertical) position. There were two metal mattress keepers on the bed and the mattress was sitting on top of the mattress keepers which allowed the mattress to slide away from the bed rail, which created a gap between the mattress and the bed rail.

-A bed in an identified room had an identified mattress. There were two quarter length, rotating assist bed rails on either side of the bed, both bed rails were in the guard position. There were four plastic mattress keepers on the bed. The mattress was sitting on top of the mattress keepers at the foot of the bed, which caused the mattress to slide away from the bed rail, which created a large gap between the mattress and bed rail. Both bed rails on the bed were loose.

-A bed in an identified room had an identified mattress, a type of mattress with soft air filled cells along the entire length of the mattress. There was one quarter length bed rail on the side of the bed closest to the window. There were four plastic corner keepers on the bed. The mattress was sitting on top of the mattress keepers which caused the mattress to slide away from the bed rail, which created a large gap between the mattress and bed rail. Both bed rails on the bed were loose.

- A bed in an identified room had an identified mattress, two rotating assist bed rails, one on either side of the bed. The bed rail closest to the window was in the assist position, and the rail closest to the door was in the guard position. Both bed rails were loose, there was a large gap between the mattress and the bed rail on both sides.

-In addition, Inspectors #690 and #679 noted the following beds in eight identified rooms that had only one quarter length rotating assist bed rail on the bed. The mattresses were sitting on top of the mattress keepers, which caused the mattress to slide away from the bed rail and created a gap between the mattress and the bed rail. These beds were documented as passing all zones on the bed entrapment inspection sheet.

Inspector #690 requested maintenance care records for bed entrapment evaluations that were completed after the annual inspection that took place in May 2018, for six identified beds and noted that on many of the maintenance care records, it was indicated that bed entrapment was completed and was "okay". The records did not indicate which entrapment zones were tested or if there were any corrections made to the bed or if there were any entrapment zone failures. The Director of Care indicated that if the maintenance care records indicated that the bed entrapment was completed or okay, then it

indicated that the bed passed all entrapment zones.

Inspectors #690 and #679 and the Director of Care (DOC) observed Maintenance worker (MW) #117, who acknowledged that they were one of the staff responsible for completing bed evaluations and also trained new employees on the procedure, demonstrate the home's process of bed evaluations. It was noted that maintenance worker #117 did not follow the HCG document for bed evaluations during the demonstration. MW #117 indicated that they did not record the entrapment zones tested and they did not know where each entrapment zones was and that the rotating assist bed rails were not tested in the assist position. During an observation of a bed evaluation in an identified room on a bed that was equipped with a Roho mattress, the bed failed entrapment zone two, as the large end of the cone entered the space between the mattress and bed rail with the rail in both the guard and assist position. A demonstration of the bed evaluation in another identified room by MW #117 indicated that the air mattress failed both zones two and three when tested. An additional demonstration of a bed evaluation in an identified room on a bed that was equipped with only one rotating assist bed rail was conducted. It was noted and pointed out to MW #117 and the DOC that the mattress was sitting on top of the mattress keepers and would slide away from the mattress and the entrapment evaluation could not be properly completed. The DOC acknowledged that all beds with only one rail, that had mattresses sitting on top of the mattress keepers would not pass the entrapment evaluation.The DOC further indicated that the home's current bed entrapment inspection sheet did not indicate which beds have only one rail as many of the beds on the inspection sheet were documented as having a "single rail", had two bed rails on the bed.

In an interview with Inspector #690, the DOC indicated that all beds in the home would be evaluated yearly, on all new admissions and with any equipment changes made to the mattress or bed. The DOC acknowledged that the Bed Entrapment Inspection Sheet should indicate whether a bed had one or two bed rails, if there were any failures of any zones and what was done to correct the failure. The DOC acknowledged that all beds with only one rail, that had mattresses sitting on top of the mattress keepers would not pass the entrapment evaluation. The DOC further indicated that the beds in the home had not been evaluated according to the HCG document and that they should have been.

In an interview with Inspector #690, the Administrator indicated that maintenance worker #117 last had training when the home purchased the tool several years ago. The Administrator further indicated that the beds had not been evaluated according to the HCG document, and that all maintenance workers would have to be re-educated on the correct process in order for the beds to be evaluated according to the HCG document.

The severity of this issue was determined to be a level three, as there was actual harm. The scope of the issue was a level three, as the number of incomplete bed rail evaluations was widespread. The home had a level three compliance history with one or more related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10 that included:
-Voluntary Plan of Correction (VPC) issued October 21, 2016, (2016_433625_0019).

(690)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2019

Order # / Ordre no : 002

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

1. Amend the home's existing electronic "Bed Safety Assessment" form so that it includes 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 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". In addition to the current questions, the amended assessment shall include
a) questions related to medical condition, medication use, behaviours, toileting habits and any other relevant risk factors prior to the application of any bed rail or bed system accessory (bed remote control) or alternative to bed rails (bolster, positioning rolls, roll guards);and
b) the alternative or alternatives that were trialed prior to applying one or more bed rails and document whether the alternative was effective or not during a specified observation period.

Reassess all residents that have bed rails utilizing the amended bed safety

assessment form.

2. Develop or acquire information fact sheets or pamphlets identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks/hazards of bed rail use, available alternatives to bed rails, how residents are assessed upon admission, how bed systems are evaluated for entrapment zones, the role of the Substitute Decision Maker (SDM) and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails. This information shall be disseminated to relevant staff, families and residents (if residents are their own decision maker).

3. Ensure that all registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other hazards, 2006" and 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, in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

4. Provide training to all relevant staff who participate in the assessment and observation of residents to establish any safety risks related to the use of bed rails and maintain a record of attendance.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and that the residents' bed systems were evaluated in accordance with prevailing practices to minimize risk to the resident.

The licensee's bed rail use clinical assessment form and process was reviewed by Inspector #690, and it was determined that it was not fully developed in accordance with the Clinical Guidance document identified in the above mentioned notice issued to Long-Term Care Home Administrators. The companion documents referenced in the notice 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 were made that where bed rails are used for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing risks and implemented where necessary. The assessment guideline offers example key assessment questions that guides decision-making such as the resident's history of falls from bed, previous bed rail use, communication limitations, their mobility, cognitive status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors and the entrapment status of the resident's bed.

The guidance document also emphasizes the need to document clearly whether alternatives to bed rails were used, and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or the SDM and any other interdisciplinary team members, would be made about the necessity and safety of the bed rail use for a particular resident and details documented on a form (electronically or paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the resident or the SDM), the size or type of the bed rail to be applied (rotating assist, fixed assist, 1/4, 1/2, 3/4 bed rail), when the bed rails are to be applied, how many bed rails, on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

A review of the home's policy by Inspector #690, titled "Bed Rail Safety Guidelines V-II-10.20 (a)" dated April 2018 indicated that if bed rails were used, staff would conduct an individualized assessment that should include consideration into; medical diagnosis, conditions, symptoms, behavioural symptoms,exsistence of delirium, sleep habits, medication, acute medical or surgical interventions, ability to toilet self, cognition, communication, mobility and risk of falling. The policy further indicated that the sleep environment would be assessed and include consideration into pain, comfort, hydration, temperature of the room, lighting, sleep regimes, toileting patterns and bed mobility. A review of an additional policy titled "Bed Rails VII-E-10.20", last revised May 2017,

indicated that a quarterly assessment of bed rails would be done for a resident's use or removal of bed rails.

A) Resident #001's bed was observed on an identified date by Inspector #690 to have a specified bed rail configuration.

Inspector #690 reviewed the above mentioned CI report and conducted a review of resident #001's electronic health records, which identified a document titled "Bed safety assessment V2". The bed safety assessment had been initiated on an identified date and completed 42 days later, on the day of the incident mentioned in the CI report. The assessment indicated that bed rails were not required and were not indicated for resident #001. The assessment included a reference to the incident that the CI report was submitted to the Director for, and that resident #001's SDM consented to the bed rails being removed from the bed. A further review of electronic health records identified a bed safety assessment that was initiated on an identified date, that was not completed until approximately 14 weeks later. The assessment identified that resident #001 required a specified level of assistance by staff for identified activities of daily living (ADL) and that bed rails were not required for resident #001. The assessment indicated that bed rails were contraindicated for resident #001 as a result of the outcome of the sleep evaluation, but that bed rails would be used, and resident #001 had a specified bed rail configuration to be used at specified times. The assessment further indicated that alternatives to the bed rails were not tried. The bed safety assessment did include a component related to evaluating the resident's sleep pattern, habits and behaviours while sleeping in bed, movement patterns, cognitive status, a history of falling from bed, and a history of restlessness. The assessment did not include consideration into medication use, medical diagnosis, toileting patterns or pain with or without the application of the bed rails. Additionally, the assessment did not include information on the type of bed rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on. Although the assessment included information on whether the resident or SDM requested the bed rails and that they were made aware of the risk factors associated with bed rail use, the assessment did not include information about the alternatives to bed rails being discussed with the resident or SDM.

In an interview with Inspector #690, resident #001's SDM indicated that they had

requested the bed rails on the bed as resident #001 would use the bed rails to assist with a specified ADL. They went on to state that they had been made aware of the risk factors of having the bed rails in place. The SDM indicated that resident #001 had the specified bed rail configuration at the time of the incident on the identified date. The SDM indicated that they witnessed resident #001's incident related to their bed system. The SDM further indicated that they were not informed of what alternatives could be used in place of the bed rails.

In an interview with Inspector #690, Personal Support Worker (PSW) #119 indicated that at the time of the incident, resident #001 had a specified bed rail configuration on the bed. PSW #119 indicated that they had found resident #001 at the time of the incident. PSW #119 indicated that at the time of the incident, resident #001 was not capable of using the bed rails to assist with a specified ADL, that resident #001 required a specified level of assistance by staff to perform the ADL, and they were unsure why the bed rails were in place. PSW #119 indicated that they participated in the assessment of the use of bed rails by completing a sleep observation during the night shift. PSW #119 indicated that they would observe residents and answer a series of questions under the support actions on Point of Care (POC). PSW #119 further indicated that the sleep observation did include observing the movement patterns of a resident and whether the call bell was within reach, but that the observation did not include observing a resident's toileting patterns, the presence of pain, or any communication issues related to the safe use of bed rails.

In an interview with Inspector #690, Registered Nurse (RN) #111 indicated that they were working when the incident mentioned in the CI report occurred, and were called to resident #001's room by PSW #119. They indicated that they observed the incident with resident #001 involving their bed system. RN #111 indicated that resident #001 sustained injuries from the incident and that they sent resident #001 to the hospital. RN #111 indicated that resident #001 was not capable of using bed rails for performing a specified ADL at the time of the incident and could not recall the bed rail configuration at the time of the incident. RN #111 indicated that they did not participate in the bed safety assessments of residents, and the assessments were completed by Registered staff on days.

In an interview with Inspector #690, Registered Practical Nurse (RPN) #120, who was also one of the Resident Assessment Instrument (RAI) Coordinators for

the home, indicated they were responsible for completing bed safety assessments on residents to determine if a resident was safe to have bed rails. RPN #120 indicated that assessments were to be completed on a quarterly basis and when there was a change in a residents status. RPN #120 further indicated that the assessment should be completed within 14 days of being initiated. RPN #120 indicated that resident #001 was not capable of utilizing the bed rails at the time of the incident, and that according to the bed safety assessment, bed rail use was contraindicated for resident #001; however the SDM for resident #001 requested the rails remain in place. Together Inspector #690 and RPN #120 reviewed the last three bed safety assessments for resident #001, and RPN #120 indicated that resident #001's assessments did not include information on the type of bed rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on, a component related to consideration into medication use, medical diagnosis, toileting patterns or pain. RPN #120 further indicated that resident #001's bed safety assessment did not include a component to indicate that alternatives to bed rails had been attempted and, the effectiveness of the alternative or that the assessment had information on the type of rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on. They indicted that although the assessment included information on whether the SDM requested the bed rails, the assessment did not include a component to indicate that alternatives to bed rails were discussed with the SDM. They also indicated that the assessments were not completed on a quarterly basis and that they should have been.

B) Resident #008's bed was observed to have a specified bed rail configuration. The bed rails were both in a specified position and the resident was in bed at the time of the observation. The bed was in an identified position, there were three additional identified falls prevention devices present.

Inspector #690 reviewed health records for resident #008 and identified a bed safety assessment was initiated on an identified date and completed 27 days later. The bed rail assessment indicated that the bed rails were in place due to request by resident #008's SDM. The bed safety assessment for resident #008 indicated that resident #008 was not capable of using the bed rails and that bed rails were contraindicated. The bed safety assessment did not include a component related to consideration into medication use, medical diagnosis, toileting patterns or pain with or without the application of the bed rails. The

assessment did not include information on the type of bed rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on.The bed safety assessment further did not include a component to indicate that alternatives to bed rails had been attempted and the effectiveness of the alternative. Although the assessment included information on whether the SDM requested the bed rails, the assessment did not include a component to indicate that alternatives to bed rails were discussed with the SDM.

In an interview with Inspector #690, PSW #118 indicated that resident #008 had a specified bed rail configuration. PSW #118 indicated that resident #008 was not capable of using the bed rails for an identified ADL, that they used to be at risk of falling from bed, but was no longer at risk of falling. They further indicated that resident #008 had always had the bed rails, and they had never observed them without the bed rails.

In an interview with RPN #120, they indicated that resident #008 had a specified bed rail configuration on their bed and that resident #008 was not capable of using them for an identified ADL. They further indicated that the only reason resident #008 had the bed rails was because of a request. RPN #120 indicated that resident #008's bed safety assessment from the identified date, was not completed within the required time frame, on a quarterly basis and that it did not include information on the type of bed rail (rotating assist, or fixed assist), and what side of the bed the bed rails were to be on, and a component related to consideration into medication use, medical diagnosis, toileting patterns or pain. RPN #120 further indicated that resident #008's bed safety assessment did not include a component to indicate that alternatives to bed rails had been attempted and the effectiveness of the alternative or that the assessment had information on the type of rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on. They indicted that although the assessment included information on whether the SDM requested the bed rails, the assessment did not include a component to indicate that alternatives to bed rails were discussed with the SDM.

C) Resident #009 was observed to have a specified bed rail configuration. The resident was in bed at the time of the observation. The bed was in an identified position, there were three additional identified falls prevention devices in place.

Inspector #692 reviewed health records for resident #009 and identified a bed safety assessment from an identified date. The bed safety assessment indicated that bed rails were in place at the request of the residents SDM and that bed rails were contraindicated for resident #009. The bed safety assessments did not include a component related to consideration into medication use, medical diagnosis, toileting patterns or pain with or without the application of the bed rails. The bed rail risk assessment did not include a component to indicate that alternatives to bed rails had been attempted and the effectiveness of the alternative. The assessment did not include information on the type of bed rail (rotating assist, or fixed assist) and what side of the bed the bed rails were to be on.

In an interview with Inspector #690, PSW #118 indicated that they did participate in the bed rail assessment of residents and document on their movement patterns, whether the call bell was within reach, if the resident was observed on the left or the right side of the bed and if the resident had an undisturbed sleep. They did not observe or document on toileting habits, continence, or pain related to the use of bed rails. PSW #118 indicated that resident #009 had a specified bed rail configuration on their bed. PSW #118 indicated that resident #009 was not capable of using the bed rails for an identified ADL and required a specified level of assistance by staff for the identified ADL.

In a interview with Inspector #690, RPN #110 indicated that resident #009 no longer used their bed rails for the identified ADL, that there was a change in their health status and that the only reason that resident #009 had the bed rails was due to a request.

In an interview with Inspector #690, Nurse Manager (NM) #102, indicated that they were responsible for completing the bed rail risk assessments for residents upon admission, with any change in the resident's bed system or a significant change in a resident's status and on a quarterly basis. NM #102 indicated that the assessment did not include consideration into medication use, medical diagnosis, toileting patterns or pain with or without the application of the bed rails. NM #102 further indicated that alternatives to bed rails were not attempted prior to the application of bed rails for resident #001, #008 or #009. Additionally NM #102 indicated that the assessments were to be completed on a quarterly basis and that assessments for resident #001 and #008 were not completed on

a quarterly basis and that they should have been.

In an interview with Inspector #690, the DOC indicated that they were aware of the HCG documents, and what was included in the documents related to the clinical assessment of the resident regarding the use of bed rails. The DOC indicated that the home's process for assessing the risk versus benefit use of the bed rails did not include medical diagnosis, behaviours, medication use pain or toileting patterns with or without the use of bed rails. The DOC also identified that the home did not attempt alternatives to the use of bed rails for resident #001, #008, and #009 prior to the application of the bed rails and that the home's process for completing the bed rail risk assessment was not done in accordance with the current prevailing practices for all residents. [s. 15. (1) (a)]

The severity of this issue was determined to be a level three, as there was actual harm. The scope of the issue was a level three, as the number of incomplete bed rail assessments was widespread. The home had a level three compliance history with one or more related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10 that included:
-Voluntary Plan of Correction (VPC) issued October 21, 2016, (2016_433625_0019).

(690)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 02, 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 15th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tracy Muchmaker

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