Ontario

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

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: April 23, 2025
Inspection Number: 2025-1258-0002
Inspection Type: Critical Incident
Licensee: Shanti Enterprises Limited
Long Term Care Home and City: Royal Terrace, Palmerston

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 7-11, 15-16 & 22-23, 2025

The following intake(s) were inspected:

- Intake: #00141892 - 2767-000004-25: related to a fall of resident

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

Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Bed rails

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 18 (1)

Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's 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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
- Amend or revise the Home's internal policies and procedures related to Bed Rails to clearly guide staff in evaluating bed systems and in assessing residents where bed rails are used, ensuring the policies/procedures include the evidence-based practice, if there are none, then prevailing practices in compliance with the Act and its related regulations. The policy should include but not be limited to the development of a risk focused bed rail assessment tool, the use of an interdisciplinary team for the assessment of bed rails and decisions to remove bed rails, assessment of residents over a period of time, reassessment if there are changes in their condition and a clear process for documenting use of bed rails in the resident's plan of care and obtaining consent.
- Managers to review the revised policy related to Bed Rails and bed systems and re-educate all registered staff and any other staff involved in bed rails management. Keep a record of the training materials used and document the education provided, including the names of the staff in attendance, date, and duration of the training, and who provided the education.
- Re-assess all residents using the amended policy related to Bed Rails and bed management systems before applying one or more bed rails for all residents as

described in the evidence-based practices, if there are none, prevailing practices.
- Amend or revise the Home's internal policies related to bed rails to ensure it includes a process for when bed rails are added, an entrapment audit is triggered.
- Prepare an educational document for resident's, families and staff about bed system regulations, alternatives to bed rails, the specific types of risks associated with bed rail use and the misconception that bed rails are necessary for all residents.

Grounds

In August of 2023 the Ministry of Long-Term Care issued a memo titled, "Use of Bed Rails in Long-Term Care Homes," which offered guidance to clarify requirements and expectations around the proper use of bed rails. It included reference to a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as a guiding best practice document in Long-term Care Homes". The Health Canada Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources."

Multiple residents were observed to have full length bed rails on their beds. The home had not adhered to evidence-based practices or prevailing practice for the safe use of bed rails to minimize risk of harm to residents.

A. The Licensee failed to ensure where bed rails were used, a) the resident was assessed and the resident's bed system was evaluated in accordance with evidence-based practices to minimize risk to residents, b) steps were taken to prevent entrapment and c) safety issues related to the use of bed rails were addressed including latch reliability and height.

A bed rail was brought in for a resident in. The home did not have a process to determine whether the bed rail was appropriate for the resident and did not complete an interdisciplinary assessment. Alternatives to the bed rails were not

explored and the resident was not reassessed when the bed rail was removed several months later due to an entrapment risk that was identified during the inspection. The bed rail had been in place for ten months.

The Director of Care (DOC) said that they did not follow specific best practice documents regarding use of bed rails.

A Registered Practical Nurse (RPN) said their practice for a conducting bed entrapment test did not include consideration of bed rail height or latch reliability and they were unsure what those terms meant.

The resident was at risk of not having the appropriate equipment when the home did not implement best practice guidelines when assessing the resident and evaluating the bed system. This included a risk of entrapment when a bed rail was not evaluated for entrapment risk for several months.

Sources: resident's clinical record, inspector observations of the resident's bed system. Use of bedrails/assist rail policy, Bed entrapment policy, interviews with the DOC and others.

B. The licensee failed to ensure that where bed rails are used, a) a resident was assessed and the resident's bed system was evaluated in accordance with evidence-based practices to minimize risk to residents and c) steps were taken to prevent entrapment and safety issues related to the use of bed rails were addressed including latch reliability and height.

The home did not adhere to best practice documents regarding use of bedrails for a resident. Entrapment test audits performed by a RPN did not include a review of bedrail height or latch reliability.

A resident was at risk of not having the appropriate equipment when the home did

not follow best practice guidelines when assessing the resident and evaluating the bed system.

Sources: A resident's clinical record, inspector observations of a resident bed system, Use of bedrails/assist rail policy, Bed entrapment policy, interviews with DOC and others

This order must be complied with by June 4, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.