Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 20, 2017	2017_539120_0014	027702-16	Follow up

Licensee/Titulaire de permis

BARTON RETIREMENT INC.
1430 UPPER WELLINGTON STREET HAMILTON ON L9A 5H3

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

THE WELLINGTON NURSING HOME
1430 UPPER WELLINGTON STREET HAMILTON ON L9A 5H3

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 23 & 24, 2017

An inspection (2016-341583-0012) was previously conducted June 16 to July 7, 2016 at which time non-compliance was identified with respect to bed system evaluations and an order was issued on August 22, 2016. The conditions laid out in the order included two components to ensure that the bed systems in the home were being evaluated and monitored for entrapment and, lastly a component related to staff training. For this follow up inspection, the conditions were noted to have been met.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurse and personal support workers.

During the course of the inspection, the inspector toured the home and observed the bed systems, reviewed bed safety policies and procedures, bed entrapment audit results and resident clinical records.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #002	2016_341583_0012	120

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, that the resident was assessed in accordance with prevailing practices, to minimize risk to the resident.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidelines includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources".

Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative

interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

For this inspection, three residents (#100, #101, #103) were selected for review to determine whether they were assessed for bed rail safety in accordance with the clinical guidance document and if any safety risks were identified and mitigated. It was determined that the staff who participated in the assessments of the residents, where bed rails were used, did not complete or full assess the residents in accordance with the directions as specified in the clinical guidance document.

According to the licensee's "Bed Rail" policy NUR-V-52 dated October 2016, and the Director of Care, all residents were to be assessed by a Registered Nurse (RN) using their "Bed Rail Risk Assessment" (BRRA) form. Each resident using bed rails was to be assessed upon admission, re-admission, when the resident's bed was replaced or when the resident had a change in condition. The policy however did not include several key processes in establishing independent knowledge about a resident's risk in using one or more bed rails, the first being the process of observing residents while sleeping in bed for a period of time with and without bed rails, especially those that were newly admitted. Secondly, the process of trialling alternatives to bed rails was not clearly described in the policy, identifying several fall prevention interventions as opposed to bed rail alternatives.

According to an RN, for newly admitted residents, the BRRA form was completed before the resident spent one night in their bed, without any independent observations of the residents' sleep habits, patterns and behaviours. If the RN, in consultation with the

resident and/or their SDM decided that if a bed rail was going to be used, a determination was made if the bed rail was a personal assistive services device (PASD) or a restraint. The risk related portion of the assessment included whether the bed system either passed or failed any zones of entrapment. No direction was provided to staff to determine what sleep patterns, habits or behaviours would be monitored while residents were asleep, for how long and which patterns and behaviours were considered a risk factor for bed safety related injuries or entrapment when bed rails were applied. Personal support workers (PSW) identified that they monitored residents for bed mobility by identifying if the resident required any assistance for turning or positioning and how many staff were required to assist. Their observations were documented on a "Daily Flow Sheet".

The BRRA form did not include several important factors related to bed safety as identified in the clinical guidance document. The factors include but are not limited to the resident's medication use, cognitive status, incontinence status, sleep characteristics or disorders (restlessness, position on mattress, sleep walking, vivid dreams etc), altered sensations, pain, involuntary movements, communication disabilities, whether they were able to operate the bed rails safely, acquired any injuries from the bed rail, got their arms or legs caught through the openings in the bed rail and any condition or behaviour that increases the resident's risk of becoming injured, entrapped or suspended from the bed or bed rail. The BRRA included a few relevant factors such as whether the resident fell from bed, had confusion, agitation or challenging behaviours, transferring abilities and any physical or clinical conditions placing them at risk of entrapment. The RN was to use their independent judgment in determining what entailed a "physical or clinical condition" or a "challenging behaviour that could lead to bed entrapment or bed injury when completing the form. The policy did not include the risk factors identified in the clinical guidance document and did not define the types of "physical or clinical conditions" or "challenging behaviours associated with bed safety risks.

The BRRA form did not include an “alternatives” section in order to be able to include written comments as to what exactly was trialled, when, for how long and whether the alternative(s) was successful or not. According to the licensee's "Bed Rail Policy" (NUR-V-52), a list of alternatives was listed and a statement added that they should be be considered. The alternatives included, hi-low bed, bed alarm, fall impact mattress at bedside, increased toileting, adequate pain relief and transfer poles. According to the clinical guidance document, the use of “perimeter reminders” or “border definers” such as body pillow, cushions, bolsters(soft rails), mattresses with lipped/raised edges, bed alarms, hand grips and various specific monitoring strategies and distractions (related to

toileting, pain, insomnia, repositioning, comfort) were identified as potential alternatives. Some of these particular accessories or modified equipment were not included as options in the policy to better guide RN decision making. The selection of the alternatives would have to be very specific to the resident's assessed condition after an observation period without the use of bed rails.

1. Resident #100 was observed in bed during the inspection, with quarter length bed rails elevated on both sides of the bed. The resident's written plan of care included the requirement to have "both quarter length bed rails elevated for mobility assistance when resident in bed, and to keep down when resident out of bed to prevent self transferring". The plan further included interventions to prevent the resident from attempting to self transfer in and out of bed, was identified as a moderate risk of falls and had cognitive impairment. The residents BRRA form dated January 2017, included that the resident was at risk of falling out of bed, had specific behaviours, did not transfer in/out of bed independently and therefore did not use the bed rails for transferring. The assessor identified the reason for the use of both bed rails "for bed mobility and used in assistance with staff when providing care for the resident". The resident's "Daily Flow Sheet" completed by PSWs identified that the resident, throughout the month of February 2016, required extensive assistance with one staff member for bed mobility.

During the inspection, the resident's bed rails were observed to be "elevated" and the resident was not in bed at the time. When the resident's left side bed rail (the side used to get into and out of bed) was tested, to determine how it operated, it was noted to be loose and bowed out and away from the bed. A large gap was noted between the mattress and the side of the bed rail. The gap was large enough for the inspector's arm to pass through the gap up to the shoulder. The bed rail on the opposite side of the bed was not in the same condition. The resident's PSW was shown the condition of the bed rail and asked why the bed rails were elevated? The PSW was not aware of the condition of the bed rail and did not know why they were both elevated and stated that the resident did not use the bed rails for repositioning and said that it was applied during transfers. The resident had a number of risk factors that increased their risk of bed injury, suspension or entrapment and their bed was not considered safe. Various PSWs who worked on different shifts did not report the condition of the bed rail to the maintenance department. The inspector reported the condition of the bed rail to the Environmental Services Supervisor who was unaware. They identified that the bed rail was quite loose and needed to be tightened and if not successful, would switch out the bed with bed rails in good condition. According to bed evaluation records dated between October 11 and December 16, 2016, all beds were measured with a specialized tool to

determine if there were any loose rails and gaps between the mattress and bed rail. Resident 100's bed passed all four entrapment zones at the time.

The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not. The assessor concluded that bed rails would be applied for bed mobility and the SDM was informed of the safety risks of the bed rails and consented to their use.

2. Resident #101 was observed in bed during the inspection with quarter length bed rails elevated on both sides of the bed. The resident's written plan of care included the use of both quarter length bed rails for mobility when resident in bed, but needed the assistance of one staff member to move in bed with an additional assistive accessory. The plan further included that the resident was high risk of falls, had neurological deficiencies, needed to be monitored for psychotropic medication effects, was required to have a falls prevention accessory beside the bed, had cognitive impairment, required the bed to be articulated on one end and had muscle weakness. The residents BRRA form dated December 2016, included that the resident was not at risk of falling out of bed, had cognitive impairment requiring supervision throughout the night and was dependent on staff for transferring in and out of bed. The assessor identified the reason for the use of both bed rails "for bed mobility and positioning". Based on the written plan of care and the BRRA, the resident was identified to have several factors that would increase their risk of bed injury, suspension or entrapment.

The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not. The assessor concluded that bed rails would be applied for bed mobility and the SDM was informed of the safety risks of the bed rails and consented to their use.

3. Resident #103 was observed in bed during the inspection, with quarter length bed rails elevated on both sides of the bed. The resident's written plan of care included the application of both quarter length bed rails and the reason provided was "to prevent resident from rolling out of bed when in bed and for mobility". The plan also included that

the resident was a low risk of falls, but required the bed to be in the lowest position "during "non-care times", was diabetic, had cognitive impairment, had neurological deficiencies and needed medication and required the assistance of two staff members to move in bed. The residents BRRA form dated January 2017, included that the resident was not at risk of falling out of bed, had cognitive impairment and no other clinical, physical or behavioural issues. The assessor identified the reason for the use of both bed rails "to keep resident from rolling out of bed and are used for safety". Based on the written plan of care and the BRRA, the resident was identified to have several factors that would increase their risk of bed injury, suspension or entrapment.

The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not. The assessor concluded that bed rails would be applied for bed mobility and the SDM was informed of the safety risks of the bed rails and consented to their use.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document to identify and mitigate safety risks to residents where bed rails were used and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. [s. 15. (1) (a)]

Additional Required Actions:

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

Issued on this 23rd day of March, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2017_539120_0014
Log No. / Registre no:	027702-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 20, 2017
Licensee / Titulaire de permis :	BARTON RETIREMENT INC. 1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3
LTC Home / Foyer de SLD :	THE WELLINGTON NURSING HOME 1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Brentnall

To BARTON RETIREMENT INC., 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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1. Resident #100 shall be re-assessed immediately in accordance with 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) to determine if their bed rail is required while in bed unsupervised, and if so, if their bed rail type presents any safety risks to the resident while in bed. Any safety risks identified shall be mitigated or interventions implemented to reduce the safety risks.

2. Amend the home's existing forms related to bed rail use and bed safety assessments to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) which is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006". The amended questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. the resident while sleeping for a specified period of time, to establish their

habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period; and
c. the resident while sleeping for a specific period of time, to establish safety risks to the resident after a bed rail has been applied and deemed necessary where an alternative was not successful; and

3. 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 the 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. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form(s) and document the assessed results and recommendations for each resident.

5. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form(s). Include in the written plan of care any necessary interventions that are required to mitigate any identified bed safety hazards.

6. Amend the existing policy "Bed Rail Policy" NUR-V-52 dated October 2016 related to the use of bed rails by residents so that it will guide an assessor in completing resident clinical assessments in accordance with the U.S. F.D.A's document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings".

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, that the resident was assessed in accordance with prevailing practices, to minimize risk to the resident.

On August 21, 2012, a notice was issued to the Long Term Care Home

Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidelines 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".

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For this inspection, three residents (#100, #101, #103) were selected for review to determine whether they were assessed for bed rail safety in accordance with the clinical guidance document and if any safety risks were identified and mitigated. It was determined that the staff who participated in the assessments of the residents, where bed rails were used, did not complete or full assess the residents in accordance with the directions as specified in the clinical guidance document.

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identified in the clinical guidance document. The factors include but are not limited to the resident's medication use, cognitive status, incontinence status, sleep characteristics or disorders (restlessness, position on mattress, sleep walking, vivid dreams etc), altered sensations, pain, involuntary movements, communication disabilities, whether they were able to operate the bed rails safely, acquired any injuries from the bed rail, got their arms or legs caught through the openings in the bed rail and any condition or behaviour that increases the resident's risk of becoming injured, entrapped or suspended from the bed or bed rail. The BRRA included a few relevant factors such as whether the resident fell from bed, had confusion, agitation or challenging behaviours, transferring abilities and any physical or clinical conditions placing them at risk of entrapment. The RN was to use their independent judgment in determining what entailed a "physical or clinical condition" or a "challenging behaviour that could lead to bed entrapment or bed injury when completing the form. The policy did not include the risk factors identified in the clinical guidance document and did not define the types of "physical or clinical conditions" or "challenging behaviours associated with bed safety risks.

The BRRA form did not include an “alternatives” section in order to be able to include written comments as to what exactly was trialled, when, for how long and whether the alternative(s) was successful or not. According to the licensee's "Bed Rail Policy" (NUR-V-52), a list of alternatives was listed and a statement added that they should be be considered. The alternatives included, hi-low bed, bed alarm, fall impact mattress at bedside, increased toileting, adequate pain relief and transfer poles. According to the clinical guidance document, the use of “perimeter reminders” or “border definers” such as body pillow, cushions, bolsters(soft rails), mattresses with lipped/raised edges, bed alarms, hand grips and various specific monitoring strategies and distractions (related to toileting, pain, insomnia, repositioning, comfort) were identified as potential alternatives. Some of these particular accessories or modified equipment were not included as options in the policy to better guide RN decision making. The selection of the alternatives would have to be very specific to the resident's assessed condition after an observation period without the use of bed rails.

1. Resident #100 was observed in bed during the inspection, with quarter length bed rails elevated on both sides of the bed. The resident's written plan of care included the requirement to have "both quarter length bed rails elevated for mobility assistance when resident in bed, and to keep down when resident out of bed to prevent self transferring". The plan further included interventions to

prevent the resident from attempting to self transfer in and out of bed, was identified as a moderate risk of falls and had cognitive impairment. The residents BRRA form dated January 2017, included that the resident was at risk of falling out of bed, had specific behaviours, did not transfer in/out of bed independently and therefore did not use the bed rails for transferring. The assessor identified the reason for the use of both bed rails "for bed mobility and used in assistance with staff when providing care for the resident". The resident's "Daily Flow Sheet" completed by PSWs identified that the resident, throughout the month of February 2016, required extensive assistance with one staff member for bed mobility.

During the inspection, the resident's bed rails were observed to be "elevated" and the resident was not in bed at the time. When the resident's left side bed rail (the side used to get into and out of bed) was tested, to determine how it operated, it was noted to be loose and bowed out and away from the bed. A large gap was noted between the mattress and the side of the bed rail. The gap was large enough for the inspector's arm to pass through the gap up to the shoulder. The bed rail on the opposite side of the bed was not in the same condition. The resident's PSW was shown the condition of the bed rail and asked why the bed rails were elevated? The PSW was not aware of the condition of the bed rail and did not know why they were both elevated and stated that the resident did not use the bed rails for repositioning and said that it was applied during transfers. The resident had a number of risk factors that increased their risk of bed injury, suspension or entrapment and their bed was not considered safe. Various PSWs who worked on different shifts did not report the condition of the bed rail to the maintenance department. The inspector reported the condition of the bed rail to the Environmental Services Supervisor who was unaware. They identified that the bed rail was quite loose and needed to be tightened and if not successful, would switch out the bed with bed rails in good condition. According to bed evaluation records dated between October 11 and December 16, 2016, all beds were measured with a specialized tool to determine if there were any loose rails and gaps between the mattress and bed rail. Resident 100's bed passed all four entrapment zones at the time.

The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was

successful or not. The assessor concluded that bed rails would be applied for bed mobility and the SDM was informed of the safety risks of the bed rails and consented to their use.

2. Resident #101 was observed in bed during the inspection with quarter length bed rails elevated on both sides of the bed. The resident's written plan of care included the use of both quarter length bed rails for mobility when resident in bed, but needed the assistance of one staff member to move in bed with an additional assistive accessory. The plan further included that the resident was high risk of falls, had neurological deficiencies, needed to be monitored for psychotropic medication effects, was required to have a falls prevention accessory beside the bed, had cognitive impairment, required the bed to be articulated on one end and had muscle weakness. The residents BRRA form dated December 2016, included that the resident was not at risk of falling out of bed, had cognitive impairment requiring supervision throughout the night and was dependent on staff for transferring in and out of bed. The assessor identified the reason for the use of both bed rails "for bed mobility and positioning". Based on the written plan of care and the BRRA, the resident was identified to have several factors that would increase their risk of bed injury, suspension or entrapment.

The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not. The assessor concluded that bed rails would be applied for bed mobility and the SDM was informed of the safety risks of the bed rails and consented to their use.

3. Resident #103 was observed in bed during the inspection, with quarter length bed rails elevated on both sides of the bed. The resident's written plan of care included the application of both quarter length bed rails and the reason provided was "to prevent resident from rolling out of bed when in bed and for mobility". The plan also included that the resident was a low risk of falls, but required the bed to be in the lowest position "during "non-care times", was diabetic, had cognitive impairment, had neurological deficiencies and needed medication and required the assistance of two staff members to move in bed. The residents BRRA form dated January 2017, included that the resident was not at risk of

falling out of bed, had cognitive impairment and no other clinical, physical or behavioural issues. The assessor identified the reason for the use of both bed rails "to keep resident from rolling out of bed and are used for safety". Based on the written plan of care and the BRRA, the resident was identified to have several factors that would increase their risk of bed injury, suspension or entrapment.

The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not. The assessor concluded that bed rails would be applied for bed mobility and the SDM was informed of the safety risks of the bed rails and consented to their use.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document to identify and mitigate safety risks to residents where bed rails were used and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

This order is based upon three factors where there has been a finding of noncompliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to s. 15(1) of O. Regulation 79/10, the scope of the non-compliance is widespread, as none of the residents who used one or more bed rails were assessed in accordance with prevailing practices, the severity of the non-compliance has the potential to cause harm to residents related to bed safety concerns and the history of noncompliance included an order issued in the same area on August 22, 2016. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2017

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of March, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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