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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 17, 2017	2017_625133_0017	005990-17	Follow up

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

WOODLAND VILLA
30 Milles Roches Road R. R. #1 Long Sault ON K0C 1P0

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

JESSICA LAPENSEE (133)

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): October 18, 19, 20, 23, 24, 25, 26, 2017

This inspection was in follow up to Compliance Order #001 issued as a result of Resident Quality Inspection #2017_548592_0006 on March 16, 2017. The compliance order related to the use of bed rails. The compliance order was reissued as a result of this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Life Enrichment Coordinator, the Environmental Service Manager, the Resident Services Coordinator, the Maintenance Worker, Personal Support Workers and residents.

The Inspector reviewed an external service provider's bed system survey document, reviewed the home's updated version of the external service providers bed system survey document, reviewed completed bed entrapment - reducing risk intervention tools, reviewed the monthly bed rail inspection document, reviewed the most current version of the licensee's side rail use assessment form, reviewed resident health care records, reviewed modified policies related to bed rails and entrapment hazards, observed resident bed systems, observed resident bed system testing process.

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)**

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 :

The Licensee has failed to ensure that where bed rails were used, residents were assessed in accordance with prevailing practices, to minimize risk to the resident.

On March 16, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Resident Quality Inspection (RQI) #2017_548592_0006. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by June 9, 2017.

The licensee was ordered, in part, to take the following action:

"Amend the home's existing "Side-Rail Use Assessment Form" in accordance with the prevailing practices outlined in "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), a companion document to the Health Canada Guidance Document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC Guidance Document). The amended form shall formally capture a risk-benefit analysis related to the use of bed rails for each resident and shall, at a minimum, include questions that can be answered by an interdisciplinary team of assessors related to:

a) the residents' sleep habits, patterns of sleep, level of comfort in bed, behaviours and other relevant factors prior to the application of any bed rails; and,

b) the alternatives that were trialed prior to using one or more bed rails, and the effectiveness of those alternatives during a specified observation period.

On August 21, 2012, a memo was issued to 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" (HC Guidance Document). In the memo, it is indicated that the Ministry expects homes to use the HC Guidance Document as a best practices document in their home.

The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States.

The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is specified that any decision to use or to discontinue use of bed rails should be made within the context of an individualized resident assessment using an interdisciplinary team. Numerous factors are to be considered and are specified. The process is to result in a documented risk benefit assessment, prior to the team's conclusion that bed rails may be indicated for use. Specific direction is provided in relation to three aspects of the required risk benefit assessment, and they are as follows:

a) Assessment of the relative risk of using bed rails compared with not using bed rails for each individual resident.

b) Identification of why other care interventions are not appropriate or not effective if previously attempted and determined not to be the treatment of choice for the resident.

c) Comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident.

The 2003 FDA Clinical Guidance document specifies that where clinical and

environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be indicated for use. The decision to use or to discontinue use of bed rails is to be made by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

On October 18, 2017, the Director of Care provided the Inspector with a copy of the most current version of the licensee's "Side-Rail Use Assessment Form".

The Inspector compared this version with the version that was in place at the time of the RQI #2017_548592_0006. The Inspector noted the following changes and additions to the assessment form: a line was added on which to list the resident's diagnosis; if established that a resident was not assessed in bed, it was now queried if not why; a question was added to query if the bed passed the entrapment test; a question related to ambulation now queried if the resident was non-ambulatory as opposed to querying if the resident was ambulatory; if established that a resident's level of consciousness fluctuates, it was now queried if the fluctuation occurred from day to evening to night; a question related to a resident's alteration in safety awareness now queried if it was due to cognitive impairment as opposed to cognitive loss; If established that a resident displayed bed mobility challenges, it was now queried if this was displayed on days/evenings/nights; if established that a resident had difficulty with postural hypotension, it was now queried if this occurred on days/evenings/nights; if established that a resident was on any medications which may require safety precautions, the examples of HS sedation, diuretics and analgesics were now given and the medications were now to be listed; a question was added to query if the bed was an appropriate height for the resident. In addition, related to the resident's sleep habits, questions were added related to if a resident sleeps all night; average number of hours in bed on days, evenings and nights; if the resident naps during the day, approximate nap times; sleep time at night, wake time in morning; pillows used for comfort; if resident gets up frequently at night to void; preferred way to void at night; if there is a toileting plan in place for each shift. A section was added titled "Previous Interventions Used for Bed Comfort Without a Side Rail". In the Interventions section, if established that frequent staff monitoring was to be provided at night, it could now be indicated if this was to be every 15 minutes, 30 minutes or every hour. In the Intervention section, bed alarm was added as a possible intervention to be selected. A section was added to indicate if there had been a multidisciplinary meeting, the date of the meeting and attendees. A section was added to indicate if the care plan had been update or not. A section was added to indicate if Family/SDM/POA updated and the name of the person contacted was to be

filled in. Finally, three spaces were added for registered staff signatures.

Upon initial review of the revised form, the Inspector noted that there were no questions related to communication. The 2003 FDA Clinical Guidance document specifies that an individual resident assessment is to include communication.

Upon initial review of the revised form, the Inspector noted that the revised form did not appear to provide for the documentation of a risk benefit assessment as per the 2003 FDA Clinical Guidance document, as referenced above.

On October 25, 2017, the Inspector met with the Resident Services Coordinator (RSC), who indicated that she completes the side rail use assessment form for all new residents, and participates in team meeting to review and discuss resident reassessments. The Inspector indicated to the RSC that the revised form did not appear to capture a documented risk-benefit assessment related to the use of bed rails, as per the 2003 FDA Clinical Guidance document. The RSC indicated that she is not documenting the risk of bedrail use on the form or in the admission note. The RSC indicated that her decision about bed rail use is coming after a few hours of observation on admission day, which would then be discussed with a multidisciplinary team the following day. The RSC indicated that if a resident's family insists that bed rails are to be used on admission day, which if often the case, they go ahead with bed rail use and the recommendations made on the assessment form for bed rail use reflects that. In that way, the determination that bed rails are indicated for use, or not, is not based on a risk benefit assessment as per the 2003 FDA Clinical Guidance document.

On October 25, 2017, the Inspector met with the Administrator and the Director of Care (DOC). Following discussion about the notion of risk benefit assessment as per the 2003 FDA Clinical Guidance document, the Administrator indicated that on the whole, the revised assessment form does not provide for a documented risk benefit assessment, nor was there a documented risk benefit assessment being captured elsewhere within the residents' health care records. The DOC agreed that a risk benefit assessment was not being documented.

On October 25, 2017, the Inspector observed the bed system belonging to resident #002. At the time of observation, there was one rotating assist rail in place, on the right side of the bed, and it was in the up position. Resident #002 was in his/her bedroom at the time of observation, sitting in his/her wheelchair, to the right of the bed.

On October 25, 2017, the Inspector observed the bed system belonging to resident #004. At the time of observation, there was one ¼ length bed rail in place, on the right side of the bed, and it was in the up position. Resident #004 was in his/her bedroom at the time of observation, sitting in his/her comfortable easy chair, to the right of the bed. Resident #004 indicated that the 1/4 rail is always kept in the up position, and that he/she uses it as a brace to steady himself/herself when he/she stands up.

On October 26, 2017, the Inspector observed the bed system belonging to resident #005. At the time of observation, there were two rotating assist rails in place. The assist rail on the right was in the down position and the assist rail on the left was in the up position. Personal Support Worker (PSW) #103 and resident #005 were in the bedroom at the time of observation. PSW #103 indicated that both rails are put into the down position when resident #005 is in bed. PSW #103 indicated that when resident #005 is ready to get up from bed, the left rail is put into the up position and resident #005 uses the rail to sit up and then the PSW transfers him/her. After the PSW left the room, resident #005 indicated that he/she does not use the rails very much, and that he/she believed that the rails were in place for protection. Resident #005 indicated that he/she holds on to the left rail sometimes when getting up. Resident #005 indicated that he/she may use the rails to turn over when in bed.

On October 25, 2017, the Inspector reviewed the health care records for resident #002, #004 and #005 and located the most recent "Side Rail Use Assessment Form" for each resident.

On October 26, 2017, the Inspector reviewed the side-rail use assessment for resident #002, #004 and #005 with the Resident Services Coordinator (RSC). The RSC confirmed that she had completed the side rail use assessment forms for the resident #004 and #005 at the time of their admission to the home, on identified dates in 2017. The RSC confirmed that she was involved in the multidisciplinary meeting, on an identified date in 2017, where resident #002's side-rail use assessment form was reviewed and discussed.

Related to resident #005, it was noted that question #7, related to the resident's balance and trunk control, had not been answered. As well, question #16, related to the amount of time the resident spends in bed, had not been answered. The RSC indicated that she would not have been able to answer these questions as it was done on admission day, and she would not have had time to gather that information. Related to the consideration of alternatives to bed rail use, the RSC indicated there was no consideration of

alternatives for resident #005. The RSC indicated that resident #005 uses his/her side rail to sit up, however, resident #005 may be able to use a transfer pole. The RSC indicated that in general, when she gets to know a resident more, and knows their strengths, she may be able to consider what alternatives to bedrails could be considered. The RSC indicated that alternatives to bed rails may therefore be considered after bed rails are put into use for a resident, and not before. The Inspector and the RSC noted that the assessment form did not provide for a documented risk benefit assessment, as per the 2003 FDA Clinical Guidance document, related to the use of bed rails for resident #005.

Related to resident #004, it was noted that questions #15, #16 and #17 had not been answered. Questions #15 inquires if the resident sleeps all night, question #16 relates to the average number of hours in bed on days, evenings and nights and question #17 inquires if the resident naps during the day. The RSC indicated that as this assessment was done on admission day, in her first three hours with the resident, she could not answer those questions. Related to the consideration of alternatives to bed rail use, the RSC indicated that the assessment form does not include questions about trialling alternatives prior to implementing bed rail use. The RSC noted that the assessment form includes the following section "previous interventions used for bed comfort without a side rail". The RSC indicated for a new resident, there is nothing to put in to that section. The RSC indicated that when the form is used for a reassessment, she will note what type of bed rails are in use at the time of the reassessment in that section, as opposed to alternatives to bed rails that may have been considered or trialed. The Inspector and the RSC noted that the assessment form did not provide for a documented risk benefit assessment, as per the 2003 FDA Clinical Guidance document, related to the use of a bed rail for resident #004.

Related to resident #002, the RSC informed the Inspector that a new side rail use assessment form had been completed for the resident, on an identified date in 2017, following an entrapment incident two days prior. Two rotating assist rails had been in use for the resident at the time. Resident #002's specified body part had become stuck in one of the assist rails. The resident was not injured as a result of the entrapment event. As a result of the incident, one of the assist rails was removed from resident #002's bed, on the identified date in 2017, when the new side rail use assessment form was completed. The Inspector and the RSC noted that the assessment form did not reference the entrapment event, nor did it provide for a documented risk benefit assessment, as per the 2003 FDA Clinical Guidance document, related to the continued use of one bed rail for resident #002.

In summary, residents, including resident's #002, #004 and #005, were not assessed in relation to bed rail use in accordance with prevailing practices, to minimize risk to the resident. The licensee has failed to fully comply with Compliance Order #001, issued as a result of Resident Quality Inspection #2017_548592_0006 on March 16, 2017. As a result of the licensee's compliance history and the widespread nature of the continuing non-compliance, a subsequent compliance order will be served on the licensee. [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 17th day of November, 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2017_625133_0017
Log No. / No de registre :	005990-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 17, 2017
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	WOODLAND VILLA 30 Milles Roches Road, R. R. #1, Long Sault, ON, K0C-1P0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janna Sabourin

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # /
Ordre no : 001

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

Linked to Existing Order /
Lien vers ordre existant: 2017_548592_0006, CO #001

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee is ordered to complete the following:

1. Revise the resident assessment process related to bed rail use to ensure that an interdisciplinary team of assessors documents a risk benefit assessment prior to the determination that beds rails are indicated for use for a resident, as per the 2003 FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings". As per the 2003 FDA Clinical Guidance document, if clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be indicated for use. Specifically, and as per the 2003 FDA Clinical Guidance document, the risk benefit assessment, which is to be documented within the resident health care record, shall provide for the following:

a) Assessment of the relative risk associated with use or non-use of bedrails to the benefits for an individual resident, including the potential for injury or death.

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

2. Amend the "Side Rail Use Assessment Form" to include consideration of the resident's communication abilities, as per the 2003 FDA Clinical Guidance document.

3. Reassess all residents with one or more bed rails in use in accordance with the revised assessment process, using the amended "Side Rail Use Assessment Form". Update the written plan of care to ensure clear directions are provided where there is continued use of one or more bed rails, identifying specific details such as what type of rail is in use on which side(s) of the bed, why they are used and time of day they are used. Include any necessary accessories or interventions that are required to mitigate any identified bed safety hazards.

Grounds / Motifs :

1. The Licensee has failed to ensure that where bed rails were used, residents were assessed in accordance with prevailing practices, to minimize risk to the resident.

On March 16, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Resident Quality Inspection (RQI) #2017_548592_0006. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by June 9, 2017.

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The Inspector compared this version with the version that was in place at the time of the RQI #2017_548592_0006. The Inspector noted the following changes and additions to the assessment form: a line was added on which to list the resident's diagnosis; if established that a resident was not assessed in bed,

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Upon initial review of the revised form, the Inspector noted that there were no questions related to communication. The 2003 FDA Clinical Guidance document specifies that an individual resident assessment is to include communication.

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On October 25, 2017, the Inspector met with the Administrator and the Director of Care (DOC). Following discussion about the notion of risk benefit assessment as per the 2003 FDA Clinical Guidance document, the Administrator indicated that on the whole, the revised assessment form does not provide for a documented risk benefit assessment, nor was there a documented risk benefit assessment being captured elsewhere within the residents' health care records. The DOC agreed that a risk benefit assessment was not being documented.

On October 25, 2017, the Inspector observed the bed system belonging to resident #002. At the time of observation, there was one rotating assist rail in place, on the right side of the bed, and it was in the up position. Resident #002 was in his/her bedroom at the time of observation, sitting in his/her wheelchair, to the right of the bed.

On October 25, 2017, the Inspector observed the bed system belonging to resident #004. At the time of observation, there was one ¼ length bed rail in place, on the right side of the bed, and it was in the up position. Resident #004 was in his/her bedroom at the time of observation, sitting in his/her comfortable easy chair, to the right of the bed. Resident #004 indicated that the 1/4 rail is always kept in the up position, and that he/she uses it as a brace to steady himself/herself when he/she stands up.

On October 26, 2017, the Inspector observed the bed system belonging to resident #005. At the time of observation, there were two rotating assist rails in place. The assist rail on the right was in the down position and the assist rail on the left was in the up position. Personal Support Worker (PSW) #103 and resident #005 were in the bedroom at the time of observation. PSW #103 indicated that both rails are put into the down position when resident #005 is in bed. PSW #103 indicated that when resident #005 is ready to get up from bed, the left rail is put into the up position and resident #005 uses the rail to sit up and then the PSW transfers him/her. After the PSW left the room, resident #005 indicated that he/she does not use the rails very much, and that he/she believed that the rails were in place for protection. Resident #005 indicated that he/she holds on to the left rail sometimes when getting up. Resident #005 indicated that he/she may use the rails to turn over when in bed.

On October 25, 2017, the Inspector reviewed the health care records for resident #002, #004 and #005 and located the most recent "Side Rail Use Assessment Form" for each resident.

On October 26, 2017, the Inspector reviewed the side-rail use assessment for resident #002, #004 and #005 with the Resident Services Coordinator (RSC). The RSC confirmed that she had completed the side rail use assessment forms for the resident #004 and #005 at the time of their admission to the home, on identified dates in 2017. The RSC confirmed that she was involved in the multidisciplinary meeting, on an identified date in 2017, where resident #002's side-rail use assessment form was reviewed and discussed.

Related to resident #005, it was noted that question #7, related to the resident's balance and trunk control, had not been answered. As well, question #16, related to the amount of time the resident spends in bed, had not been answered. The RSC indicated that she would not have been able to answer these questions as it was done on admission day, and she would not have had time to gather that information. Related to the consideration of alternatives to bed rail use, the RSC indicated there was no consideration of alternatives for resident #005. The RSC indicated that resident #005 uses his/her side rail to sit up, however, resident #005 may be able to use a transfer pole. The RSC indicated that in general, when she gets to know a resident more, and knows their strengths, she may be able to consider what alternatives to bedrails could be considered. The RSC indicated that alternatives to bed rails may therefore be considered after bed rails are put into use for a resident, and not before. The

Inspector and the RSC noted that the assessment form did not provide for a documented risk benefit assessment, as per the 2003 FDA Clinical Guidance document, related to the use of bed rails for resident #005.

Related to resident #004, it was noted that questions #15, #16 and #17 had not been answered. Questions #15 inquires if the resident sleeps all night, question #16 relates to the average number of hours in bed on days, evenings and nights and question #17 inquires if the resident naps during the day. The RSC indicated that as this assessment was done on admission day, in her first three hours with the resident, she could not answer those questions. Related to the consideration of alternatives to bed rail use, the RSC indicated that the assessment form does not include questions about trialling alternatives prior to implementing bed rail use. The RSC noted that the assessment form includes the following section "previous interventions used for bed comfort without a side rail". The RSC indicated for a new resident, there is nothing to put in to that section. The RSC indicated that when the form is used for a reassessment, she will note what type of bed rails are in use at the time of the reassessment in that section, as opposed to alternatives to bed rails that may have been considered or trialed. The Inspector and the RSC noted that the assessment form did not provide for a documented risk benefit assessment, as per the 2003 FDA Clinical Guidance document, related to the use of a bed rail for resident #004.

Related to resident #002, the RSC informed the Inspector that a new side rail use assessment form had been completed for the resident, on an identified date in 2017, following an entrapment incident two days prior. Two rotating assist rails had been in use for the resident at the time. Resident #002's specified body part had become stuck in one of the assist rails. The resident was not injured as a result of the entrapment event. As a result of the incident, one of the assist rails was removed from resident #002's bed, on the identified date in 2017, when the new side rail use assessment form was completed. The Inspector and the RSC noted that the assessment form did not reference the entrapment event, nor did it provide for a documented risk benefit assessment, as per the 2003 FDA Clinical Guidance document, related to the continued use of one bed rail for resident #002.

In summary, residents, including resident's #002, #004 and #005, were not assessed in relation to bed rail use in accordance with prevailing practices, to minimize risk to the resident. The licensee has failed to fully comply with Compliance Order #001, issued as a result of Resident Quality Inspection

#2017_548592_0006 on March 16, 2017. As a result of the licensee's compliance history and the widespread nature of the continuing non-compliance, a subsequent compliance order will be served on the licensee. [s. 15. (1) (a)] (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2018

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
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 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 17th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : JESSICA LAPENSEE

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