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 # / Registre no	Type of Inspection / Genre d'inspection
Aug 10, 2016	2016_189120_0045	020023-16	Critical Incident System

Licensee/Titulaire de permis

UNITED MENNONITE HOME FOR THE AGED
4024 Twenty-Third Street Vineland ON L0R 2C0

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

UNITED MENNONITE HOME
4024 Twenty-Third Street Vineland ON L0R 2C0

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): July 15, 2016

Critical Incident #2951-000014-16 was submitted in July 2016 related to an incident involving a resident and their bed system.

During the course of the inspection, the inspector(s) spoke with the Director of Care, staff educator/Assistant Director of Care, RAI Co-ordinator/Wound Care Nurse, registered and non-registered staff.

During the course of the inspection, the inspector toured one home area, observed several bed systems and the identified resident in bed, reviewed the home's bed rail risk assessment form, bed rail safety policy and several 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)**

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 did not ensure that where bed rails were used, that the resident was assessed in accordance with evidence-based 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 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". 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 (medical device). 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.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined not to be developed in accordance with the Clinical Guidance document identified above. According to the Director of Care, the Clinical Guidance document was reviewed by herself and her senior management staff but many of the processes and questions were not incorporated into their existing processes and questionnaire titled "Bed Rail Risk Assessment" which was developed in 2015. The form was used to assess only those residents who were admitted to the home after May 2015 for bed rail use/safety. Residents who had been admitted prior to that date and who used bed rails were not assessed in the same manner.

A) The clinical assessment process did not incorporate a process by which the resident's sleep patterns, habits and behaviours could be evaluated or observed while sleeping in bed with or without the application of bed rails. There were no details as to how the assessment of residents would be conducted. The home's policy related to bed rails revised in July 2015 did not include any written procedures for staff guidance. Neither the form nor the policy included information regarding if/how long residents were to be observed, the dates that they were observed and the specific behaviours that were to be monitored during the observation period. The Bed Rail Risk Assessment form did not include any questions related to sleep patterns or behaviours with the exception of whether the resident was capable of getting out of bed unsupervised and if they were at risk for climbing over the bed rails.

Discussion with management staff revealed that the clinical assessments were conducted upon admission and that they did not have adequate information about the resident's sleeping habits and patterns to document the necessary information on the assessment form.

Resident #001, was admitted to the home prior to May 2015 and was not assessed for potential bed rail safety risks prior to the application of bed rails and in receiving a therapeutic surface/mattress in June 2016. On a specified date in July 2016, the resident was discovered by an RN who observed that the resident had partially fallen out of their bed (which was in the lowest position). The bed rail acted as a "stop" for the resident from falling straight down to the floor which was not the intended purpose of the bed rail. Post incident, the bed rails were tied down and the therapeutic mattress was replaced with a different type of therapeutic mattress. The resident was not injured but the potential for serious injury was higher based on the resident's specific condition and medical needs. Some of the risk factors identified by the prevailing practices includes but is not limited to cognition, medication use, having past behaviour of climbing over the bed rails, having a history of falling from bed, mobility, comfort, pain, sleep habits and communication issues. According to an RN responsible for skin and wound care and for determining the benefits of therapeutic surfaces, the bed rails were applied automatically once the resident received the mattress in June 2016 assuming that the rails contributed to securing the mattress in place. According to the RN who witnessed the resident on the floor, the resident was not able to reposition themselves and relied on staff to guide the resident to hold onto the bed rail but was able to move somewhat while in bed. The bed rail in this case would have been difficult to use by the resident if needed for repositioning as it was approximately at the same height as the air mattress. Shortly following this incident, the same resident sustained a minor injury involving their bed rail in July 2016 when they slid off their therapeutic mattress and got their arm caught in zone 1 (within the rail) of their bed rail. The bed rail was not in use at the time and was tied down to the frame of the bed. Due to bed design, a small gap was present between the bed frame and the side of the bed rail which was large enough for the resident's arm to slip into that particular zone. The licensee subsequently removed both bed rails from the bed post incident and provided the resident with a firmer foam mattress with raised perimeter edges.

Resident #002 was admitted in June 2015 and their bed rail risk clinical assessment was completed the following day. The assessor identified the resident's condition and medical needs to include those characteristics identified by the prevailing practices as

risk factors for bed rail entrapment. The progress notes for the first night identified the resident was "very restless in bed and moving self". The conclusion on the clinical assessment form included "the resident's SDM requested two full bed rails applied for "reassurance and safety". The term "safety" was not defined. The bed rails were padded, but no reason was given in the assessment, however during the inspection, the ADOC stated that the pads were to prevent bed rail injuries. The resident was not independently observed by registered and non registered staff over a specified period of time to determine sleep patterns, behaviours and habits before bed rails were applied. The bed rails were applied immediately after the resident's admission.

Resident #003 was admitted in September 2015 and clinically assessed 2 days later. According to the resident's clinical record, the resident's condition and medical needs included characteristics identified by the prevailing practices as risk factors for bed rail entrapment. Interventions to reduce or mitigate the risk factors were not identified in the bed rail risk clinical assessment. No information was included in the progress notes or their assessment about their sleeping patterns or habits over a period of time. The assessor concluded that 2 bed rails were to be applied for "safety". The term "safety" was not defined. The plan of care dated September 2015 included information that the resident could "hold onto the bed rail when directed".

Resident #004 was admitted to the home in June 2011 and did not have a bed rail risk clinical assessment completed at the time of inspection. The resident's bed was observed to have one quarter sized bed rail elevated on their bed on July 15, 2016 but was not in bed at the time. The resident's written plan of care dated May 2016 included that the resident required 2- 1/4 rails for holding themselves on their side and had several characteristics identified by the prevailing practices as risk factors for bed entrapment. No documentation was available for review to determine how the resident was evaluated and for how long and by whom and whether any of the above noted risk factors were included in deciding whether a bed rail was a safe alternative for the resident.

B) The Bed Rail Risk Assessment form did not identify what alternatives were trialled to minimize or eliminate the risks of strangulation, suspension, entrapment, entanglement, injuries, skin tears or bruising if bed rails were to be applied. Bed rail alternatives would include but not be limited to a transfer pole, raised perimeter mattress (easier to grab than a flat mattress when being repositioned), adjustable bolsters (also known as soft rails) or teaching the resident new transfer or re-positioning techniques. Residents #001, #002, #003 or #004 did not have any alternatives trialled prior to the decision to apply bed rails.

C) The questions included on the Bed Rail Risk Assessment form did not include many key questions related to sleep patterns, falls history, behaviours, bed mobility and medication use. Only 4 questions were available for completion related to resident mobility (capable of getting out of bed unsupervised), involuntary movements, cognition and risk for climbing over bed rails. A conclusion section was available after the questions for written comments, which revealed in some cases, a decision based upon the demands or requests of SDMs.

The DOC identified that she and her registered staff have felt pressured by the resident's SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation.

D) The Bed Rail Risk Assessment form did not specify what interdisciplinary staff members participated in the evaluation of the residents. The assessment forms reviewed did not have any names listed on the form. [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 11th day of August, 2016

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 :	2016_189120_0045
Log No. / Registre no:	020023-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 10, 2016
Licensee / Titulaire de permis :	UNITED MENNONITE HOME FOR THE AGED 4024 Twenty-Third Street, Vineland, ON, L0R-2C0
LTC Home / Foyer de SLD :	UNITED MENNONITE HOME 4024 Twenty-Third Street, Vineland, ON, L0R-2C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Walter Sguazzin

To UNITED MENNONITE HOME FOR THE AGED, 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)

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. Amend the home's existing "Bed Rail Risk Assessment " form 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) 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". The amended questionnaire shall, at a minimum, include:

a) questions that can be answered by the assessors related to 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 the application of one or more bed rails and document whether the alternatives were effective during the specified period of time; and

c) include the names of the interdisciplinary team members who participated in

evaluating the resident; and

d) provide clear written direction or alternative (i.e decision tree) to assist the assessor(s) in answering the questions when determining whether bed rails are a safe alternative for the resident being assessed.

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

3. 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. Include in the written plan of care any necessary accessories or interventions that were required to mitigate any identified bed safety hazards.

4. Obtain or develop an education and information package that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, how beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts associated with bed systems and the use of bed rails.

5. Amend the "Bed Rails" policy revised in July 2015 and associated forms and procedures to include all of the above noted requirements and any additional relevant information noted in the prevailing practices identified as 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) and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". All registered and non-registered staff shall be informed about the amended policy, forms and procedures.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, that the resident was assessed in accordance with evidence-based 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 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". 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 (medical device). 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.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined not to be developed in accordance with the Clinical Guidance document identified above. According to the Director of Care, the Clinical Guidance document was reviewed by herself and her senior management staff but many of the processes and questions were not incorporated into their existing processes and questionnaire titled "Bed Rail Risk Assessment" which was developed in 2015. The form was used to assess only those residents who were admitted to the home after May 2015 for bed rail use/safety. Residents who had been admitted prior to that date and who used bed rails were not assessed in the same manner.

A) The clinical assessment process did not incorporate a process by which the resident's sleep patterns, habits and behaviours could be evaluated or observed while sleeping in bed with or without the application of bed rails. There were no details as to how the assessment of residents would be conducted. The home's policy related to bed rails revised in July 2015 did not include any written procedures for staff guidance. Neither the form nor the policy included information regarding if/how long residents were to be observed, the dates that they were observed and the specific behaviours that were to be monitored during the observation period. The Bed Rail Risk Assessment form did not include any questions related to sleep patterns or behaviours with the exception of whether the resident was capable of getting out of bed unsupervised and if they were at risk for climbing over the bed rails.

Discussion with management staff revealed that the clinical assessments were conducted upon admission and that they did not have adequate information about the resident's sleeping habits and patterns to document the necessary information on the assessment form.

Resident #001, was admitted to the home prior to May 2015 and was not assessed for potential bed rail safety risks prior to the application of bed rails and in receiving a therapeutic surface/mattress in June 2016. On a specified date in July 2016, the resident was discovered by an RN who observed that the resident had partially fallen out of their bed (which was in the lowest position). The bed rail acted as a "stop" for the resident from falling straight down to the floor which was not the intended purpose of the bed rail. Post incident, the bed rails were tied down and the therapeutic mattress was replaced with a different type of therapeutic mattress. The resident was not injured but the potential for serious injury was higher based on the resident's specific condition and medical

needs. Some of the risk factors identified by the prevailing practices includes but is not limited to cognition, medication use, having past behaviour of climbing over the bed rails, having a history of falling from bed, mobility, comfort, pain, sleep habits and communication issues. According to an RN responsible for skin and wound care and for determining the benefits of therapeutic surfaces, the bed rails were applied automatically once the resident received the mattress in June 2016 assuming that the rails contributed to securing the mattress in place. According to the RN who witnessed the resident on the floor, the resident was not able to reposition themselves and relied on staff to guide the resident to hold onto the bed rail but was able to move somewhat while in bed. The bed rail in this case would have been difficult to use by the resident if needed for repositioning as it was approximately at the same height as the air mattress. Shortly following this incident, the same resident sustained a minor injury involving their bed rail in July 2016 when they slid off their therapeutic mattress and got their arm caught in zone 1 (within the rail) of their bed rail. The bed rail was not in use at the time and was tied down to the frame of the bed. Due to bed design, a small gap was present between the bed frame and the side of the bed rail which was large enough for the resident's arm to slip into that particular zone. The licensee subsequently removed both bed rails from the bed post incident and provided the resident with a firmer foam mattress with raised perimeter edges.

Resident #002 was admitted in June 2015 and their bed rail risk clinical assessment was completed the following day. The assessor identified the resident's condition and medical needs to include those characteristics identified by the prevailing practices as risk factors for bed rail entrapment. The progress notes for the first night identified the resident was "very restless in bed and moving self". The conclusion on the clinical assessment form included "the resident's SDM requested two full bed rails applied for "reassurance and safety". The term "safety" was not defined. The bed rails were padded, but no reason was given in the assessment, however during the inspection, the ADOC stated that the pads were to prevent bed rail injuries. The resident was not independently observed by registered and non registered staff over a specified period of time to determine sleep patterns, behaviours and habits before bed rails were applied. The bed rails were applied immediately after the resident's admission.

Resident #003 was admitted in September 2015 and clinically assessed 2 days later. According to the resident's clinical record, the resident's condition and

medical needs included characteristics identified by the prevailing practices as risk factors for bed rail entrapment. Interventions to reduce or mitigate the risk factors were not identified in the bed rail risk clinical assessment. No information was included in the progress notes or their assessment about their sleeping patterns or habits over a period of time. The assessor concluded that 2 bed rails were to be applied for "safety". The term "safety" was not defined. The plan of care dated September 2015 included information that the resident could "hold onto the bed rail when directed".

Resident #004 was admitted to the home in June 2011 and did not have a bed rail risk clinical assessment completed at the time of inspection. The resident's bed was observed to have one quarter sized bed rail elevated on their bed on July 15, 2016 but was not in bed at the time. The resident's written plan of care dated May 2016 included that the resident required 2- 1/4 rails for holding themselves on their side and had several characteristics identified by the prevailing practices as risk factors for bed entrapment. No documentation was available for review to determine how the resident was evaluated and for how long and by whom and whether any of the above noted risk factors were included in deciding whether a bed rail was a safe alternative for the resident.

B) The Bed Rail Risk Assessment form did not identify what alternatives were trialled to minimize or eliminate the risks of strangulation, suspension, entrapment, entanglement, injuries, skin tears or bruising if bed rails were to be applied. Bed rail alternatives would include but not be limited to a transfer pole, raised perimeter mattress (easier to grab than a flat mattress when being repositioned), adjustable bolsters (also known as soft rails) or teaching the resident new transfer or re-positioning techniques. Residents #001, #002, #003 or #004 did not have any alternatives trialled prior to the decision to apply bed rails.

C) The questions included on the Bed Rail Risk Assessment form did not include many key questions related to sleep patterns, falls history, behaviours, bed mobility and medication use. Only 4 questions were available for completion related to resident mobility (capable of getting out of bed unsupervised), involuntary movements, cognition and risk for climbing over bed rails. A conclusion section was available after the questions for written comments, which revealed in some cases, a decision based upon the demands or requests of SDMs.

The DOC identified that she and her registered staff have felt pressured by the resident's SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation.

D) The Bed Rail Risk Assessment form did not specify what interdisciplinary staff members participated in the evaluation of the residents. The assessment forms reviewed did not have any names listed on the form. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2016

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 10th day of August, 2016

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