Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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

Hamilton Service Area Office
119 King Street West 11th Floor
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 11, 2017;	2017_539120_0026 (A1)	025683-16	Follow up

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) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for order #001 has been amended.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 11 day of August 2017 (A1)

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

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Ministère de la Santé et des Soins de longue durée

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4024 Twenty-Third Street Vineland ON L0R 2C0

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

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): April 21, 2017

An inspection (2016-189120-0045) was previously conducted on July 15, 2016, and non-compliance identified related to bed safety. An order was issued on August 10, 2016, with multiple conditions. For this follow up inspection, some of the conditions were not complied with and the order remains outstanding.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Associate Director of Care, RAI-MDS Co-ordinator and registered staff.

During the course of the inspection, the inspector toured all home areas, observed resident bed systems, resident clinical records and bed safety related policies, procedures and educational information.

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 :

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

The prevailing practice identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada) was identified by the Ministry of Health and Long Term Care in 2012 and provides the necessary guidance in establishing a clinical assessment where bed rails are used.

An inspection (2016-189120-0045) was previously conducted on July 15, 2016, and non-compliance identified with this section related to resident clinical assessments where bed rails were used. An order with multiple conditions was issued on August 10, 2016, for a due date of November 15, 2016. An extension was subsequently requested and granted to January 31, 2017. The order included requirements to amend the home's existing forms to include; (1) questions related to a sleep assessment of the resident prior to the application of any bed rails, (2) alternatives that were trialled prior to the application of one or more bed rails and to document whether the alternatives were effective, (3) clear written directions to assist the assessor in determining whether bed rails were a safe alternative for the resident, and (4) to amend the policy to include requirements (1) to (3) and to provide families, residents and staff with written information or education related to bed safety. Most of the requirements were confirmed to be outstanding and the

licensee's bed rail use clinical assessment form and processes were determined to not be fully developed in accordance with the Clinical Guidance document identified above.

Four residents (#001, 002, 003, 004) were randomly selected during this inspection to determine if they were assessed for bed safety risks. According to the Associate Director of Care (ADOC), the number of residents using bed rails had been reduced by approximately 50%.

A) The clinical assessment process did not include documentation of what alternatives were trialled prior to the application of bed rails for the above noted four residents. The ADOC and Director of Care (DOC) re-developed a form titled Bed Rail Assessment" (BRA) for use by registered staff to assess residents either upon admission, change in condition or at a specified frequency. The BRA form included several categories for completion including risk factors associated with an increased risk of bed system injury such as cognitive risk, level of confusion, medical status (involuntary movements, medication use, balance and trunk control, history of falls), sleep pattern (if slept through night, conditions affecting quality of sleep, independent use of bed rails) and a 72 hour sleep pattern look back, requiring the registered nurse to review the information documented by a personal support worker (PSW). An alternatives section was not included, where a list of available alternative options to bed rails could be selected, the dates trialled, the person responsible for monitoring the alternative and whether effective or not could be documented.

B) The home's policy 08.04.04 "Bed Rails" revised in July 2015 did not include any written procedures for staff guidance. The exception was a requirement that "all residents be checked for safety and security of bed rails every hour" and that registered staff "complete a bed rail assessment on admission and with significant change". The policy did not include the role of the personal support worker (PSW), an interdisciplinary team member, in conducting sleep assessments. According to the RAI-MDS co-ordinator, the PSWs were tasked at documenting (in Point of Care) whether the resident used their bed rails for turning and repositioning, if assistance was provided and whether they had insomnia or unusual sleep patterns when they were in bed, whether day or night. The task was to be observed and documented by the PSW. The frequency was established to be hourly, however documentation associated with residents #001 to #004 revealed that residents were observed only two to four times over a 24-hour period, which may be insufficient to establish adequate conclusions about a resident's sleep behaviours

and associated risks where bed rails were applied. The data was required to be reviewed by the registered nurse when completing the BRA form under the "72 hour sleep pattern look back". The questions related to these tasks did not include what types of risks the PSWs were to be looking for while the resident was in bed with a bed rail applied. No explanation was given as to what type of safety and security risks PSWs were to observe related to bed rails. The policy included a statement that "bed rails were considered a safety device" which contradicts bed safety legislation. Bed rails are services devices designed to aid residents in bed mobility and transfers.

Resident #001 was admitted to the home in 2017, and their BRA form was completed on the same date and the assessor who completed the form was therefore not able to determine what the resident's sleep patterns and behaviours were in order to identify the risks associated with bed rail use. The BRA form identified the resident with several risk factors associated with the potential for bed rail associated injury such as poor cognition, balance and trunk control issues and was on medication that required safety precautions. The resident's plan of care included that the resident had weakness on one side. This was not included in the BRA. The conclusion was that the resident would use both bed rails for turning and positioning. No documentation was available to establish what safety risks were identified, if any with bed rails applied. 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 in 2017 and no information was available to determine if alternatives were considered, and if so, which alternatives were trialled, when and if effective.

Resident #002 was observed to be in bed at the time of inspection with both quarter length bed rails elevated. No staff were present. The resident was admitted in 2015 and clinically assessed two days post admission to require extensive assistance with bed mobility. According to the resident's current written plan of care, both quarter bed rails were required only during times when staff assisted the resident with bed mobility, and left down or not applied when staff left the room. The plan of care included that the resident had cognitive loss and judgment issues, poor balance and a history of falls from bed. The BRA form completed in April 2017, included that the resident could not use the bed rails independently for bed mobility, the "level of confusion" section was blank, and identified that the resident was cognitively aware and chose to use the bed rails (in contradiction to the plan of care and other sections of the BRA).

Resident #003 was observed in bed with both quarter bed rails elevated or applied at the time of inspection. The resident was admitted in 2012, and their written plan of care did not include any bed mobility information or bed rail use information until July 2016. At that time, the only information included "one to two staff assistance". In November 2016, the resident required extensive assistance by staff to reposition while in bed. This was preceded by the completion of the BRA form dated earlier in November 2016, identifying that the resident was not to use bed rails due to risk factors associated with entrapment risk. The assessor identified that the resident was at risk of climbing over the bed rails, was not cognitively aware, was always disoriented, had balance issues, did not use the bed rails independently and had a history of falls from bed. As interventions, the resident was provided with a bed alarm and a falls prevention mat on the floor beside the bed to mitigate risk of injury from any falls in November 2016. In January 2017, the resident fell from bed and despite the level of risk associated with bed rails being applied, the substitute decision maker (SDM) insisted that bed rails be re-applied. The registered staff agreed without conducting a full assessment as required. The BRA dated January 2017, was incomplete and no alternatives were listed on the form to determine if any other interventions or alternatives were trialled before selecting the bed rails, such as soft rails or adjustable side bolsters. If bolsters were not effective, and the registered staff felt that bed rails would benefit the resident, the entrapment risk would need to be mitigated by including bed accessories designed for the specific entrapment risk. The conclusions in the assessment dated in early November 2016, were not comprehensive and did not describe the specific entrapment risk associated with the resident's bed rail.

Resident #004 was observed in bed at the time of inspection with both quarter bed rails elevated. The resident was admitted in 2014, and no information was listed in the written plan of care about their bed rail use. When re-assessed in 2016, the resident required extensive assistance to roll side to side. The residents written plan of care dated December 2016, included two quarter bed rails to assist with bed mobility. The plan of care also identified the resident at risk of falling out of bed and included interventions such as mats on the floor. The resident's BRA form dated December 2016, was not fully completed. No information was documented under the section titled "Medical" which included questions related to risk factors such as involuntary movements, medication use, balance and falls history. The BRA form included that the resident was cognitively aware and chose to use the bed rails, for bed mobility. Under the "Loss of Confusion" section, the assessor identified that the resident was "always disoriented" and that the rails could only be

used with staff supervision. The conclusion included that the resident was "cognitively intact and can ask to have rails up or down". The overall assessment was confusing and did not align with the plan of care. The risks associated with having bed rails applied were not clear and it was not clear if the resident could actually use the bed rails independently.

C) The policy provided at the time of inspection had not been amended as required in the order issued on August 10, 2016. The policy was missing staff roles and responsibilities in assessing residents who use one or more bed rails, details of the assessment process (how long residents monitored with bed rails, without bed rails, with alternatives in place), forms to be used, considerations for or against bed rail application, bed rail use risk factors, alternatives available for the replacement of bed rails, interventions available to mitigate any identified risks (i.e. padding on bed rails if bruising noted), the role of the SDM and resident in selecting the appropriate device for bed mobility, the information required to be provided to residents and SDMs, when consent for use of bed rails is required, when staff are to report bed system issues to maintenance, how registered staff are made aware of the bed entrapment status of each bed where bed rails would be applied, who evaluates the beds, how often and the procedures used and any additional applicable details necessary to ensure registered and non-registered staff involved in the process are required to have in order to fully understand and perform their duties.

D) The Director of Care identified that a brochure or pamphlet titled "A Guide to Bed Safety", was mailed out to all families/SDMs in August 2016. The pamphlet was acquired from the United States Food and Drug Administration and it included bed rail use risks and benefits, how to reduce risks, role of the SDM or family, alternatives to bed rails, bed safety statistics and contact information for citizens of the United States. The pamphlet was not customized to reflect Canadian related statistics and Health Canada contact information. The details in the order required the licensee to identify the regulations that govern hospital beds in Ontario and the prevailing practices used in Ontario (Health Canada's "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" and the two associated companion guides), how beds pass or fail entrapment zone testing and other relevant facts associated with bed systems and the use of bed rails. [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

Issued on this 11 day of August 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : BERNADETTE SUSNIK (120) - (A1)

Inspection No. / No de l'inspection : 2017_539120_0026 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 025683-16 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Aug 11, 2017;(A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

To 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)

Linked to Existing Order / Lien vers ordre existant: 2016_189120_0045, 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 shall complete the following:

1. Amend the home's existing "Resident/Bedrail Assessment " form and/or the Personal Care Observation and Monitoring Form to include:

A) Questions that can be answered by the PSWs, who have been tasked at observing the residents while in bed, that are specifically related to the resident while sleeping in bed for sleep associated behaviours or conditions associated with the potential of increasing bed related injuries after the application of any bed rails; and

B) The most appropriate alternative for the resident, including the option of soft rails (adjustable bolsters), that was trialled prior to the application of one or more bed rails (where possible) and document when the alternative(s) was trialled, who monitored the alternative and if the alternative was effective

during the specified trial time period; and

2. Amend the current"Bed Rails" policy revised in July 2015 to include any 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"specific roles and responsibilities of team members involved in assessing residents for risks related to the use of one or more bed rails. At a minimum the policy shall include;

a) details of the process of assessing residents upon admission, when a change in the resident's condition has been identified and at an established frequency to monitor residents for risks associated with bed rail use on an on-going basis; and
b) the time frames for monitoring residents without bed rails, with bed rails and with alternatives in place shall be established; and
c) guidance for the assessors in being able to make clear decisions based on the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents.
d) identification of what forms are to be used and who completes them; and
e) bed rail use risk factors; and
f) alternatives available for the replacement of bed rails; and
g) interventions available to mitigate any identified risks (i.e. padding on bed rails if bruising noted); and
h) the role of the Substitute Decision Maker (SDM) and resident in selecting the appropriate device for bed mobility; and
i) the information required to be provided to residents and SDMs about bed rail use and when consent for use of bed rails is required; and
j) when staff are to report bed system issues to maintenance; and
k) how registered staff are made aware of the bed entrapment status of each bed where bed rails would be applied; and
l) who evaluates the beds, how often and the procedures used to evaluate the beds using the cone and cylinder tool; and any additional applicable details necessary to ensure registered and non-registered staff involved in the process are required to have in order to fully understand and perform

their duties.

3. All direct care staff are to be informed about the amended bed safety policy and provided with face to face education education about bed entrapment zones, resident risk factors that are considered high risk for bed system injury or entrapment, the benefits versus the risks of bed rail use, alternatives to bed rail use, how to identify bed rails or other bed system components that are not in good working order and who to report to and when and

4. 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, the type and size of the bed rail, why it is being used, when it is to be used, how many bed rails are to be applied and on what side of the bed.

5. Amend the current pamphlet titled "A Guide to Bed Safety" or obtain 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, how beds pass or fail entrapment zone testing and the contact information for Health Canada, Medical Devices Bureau for additional information and any bed system related injury, entrapment or suspension event.

If an extension to the order due date is required, the inspector shall be contacted by email (Bernadette.susnik@ontario.ca) a minimum of two weeks prior to the due date.

Grounds / Motifs :

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

The prevailing practice identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by

Health Canada) was identified by the Ministry of Health and Long Term Care in 2012 and provides the necessary guidance in establishing a clinical assessment where bed rails are used.

An inspection (2016-189120-0045) was previously conducted on July 15, 2016, and non-compliance identified with this section related to resident clinical assessments where bed rails were used. An order with multiple conditions was issued on August 10, 2016, for a due date of November 15, 2016. An extension was subsequently requested and granted to January 31, 2017. The order included requirements to amend the home's existing forms to include; (1) questions related to a sleep assessment of the resident prior to the application of any bed rails, (2) alternatives that were trialled prior to the application of one or more bed rails and to document whether the alternatives were effective, (3) clear written directions to assist the assessor in determining whether bed rails were a safe alternative for the resident, and (4) to amend the policy to include requirements (1) to (3) and to provide families, residents and staff with written information or education related to bed safety. Most of the requirements were confirmed to be outstanding and the licensee's bed rail use clinical assessment form and processes were determined to not be fully developed in accordance with the Clinical Guidance document identified above.

Four residents (#001, 002, 003, 004) were randomly selected during this inspection to determine if they were assessed for bed safety risks. According to the Associate Director of Care (ADOC), the number of residents using bed rails had been reduced by approximately 50%.

A) The clinical assessment process did not include documentation of what alternatives were trialled prior to the application of bed rails for the above noted four residents. The ADOC and Director of Care (DOC) re-developed a form titled Bed Rail Assessment" (BRA) for use by registered staff to assess residents either upon admission, change in condition or at a specified frequency. The BRA form included several categories for completion including risk factors associated with an increased risk of bed system injury such as cognitive risk, level of confusion, medical status (involuntary movements, medication use, balance and trunk control, history of falls), sleep pattern (if slept through night, conditions affecting quality of sleep, independent use of bed rails) and a 72 hour sleep pattern look back, requiring the registered nurse to review the information documented by a personal support worker (PSW). An alternatives section was not included, where a list of available alternative options to bed rails could be selected, the dates trialled, the person responsible for monitoring

the alternative and whether effective or not could be documented.

B) The home's policy 08.04.04 "Bed Rails" revised in July 2015 did not include any written procedures for staff guidance. The exception was a requirement that "all residents be checked for safety and security of bed rails every hour" and that registered staff "complete a bed rail assessment on admission and with significant change". The policy did not include the role of the personal support worker (PSW), an interdisciplinary team member, in conducting sleep assessments. According to the RAI-MDS co-ordinator, the PSWs were tasked at documenting (in Point of Care) whether the resident used their bed rails for turning and repositioning, if assistance was provided and whether they had insomnia or unusual sleep patterns when they were in bed, whether day or night. The task was to be observed and documented by the PSW. The frequency was established to be hourly, however documentation associated with residents #001 to #004 revealed that residents were observed only two to four times over a 24-hour period, which may be insufficient to establish adequate conclusions about a resident's sleep behaviours and associated risks where bed rails were applied. The data was required to be reviewed by the registered nurse when completing the BRA form under the "72 hour sleep pattern look back". The questions related to these tasks did not include what types of risks the PSWs were to be looking for while the resident was in bed with a bed rail applied. No explanation was given as to what type of safety and security risks PSWs were to observe related to bed rails. The policy included a statement that "bed rails were considered a safety device" which contradicts bed safety legislation. Bed rails are services devices designed to aid residents in bed mobility and transfers.

Resident #001 was admitted to the home in 2017, and their BRA form was completed on the same date and the assessor who completed the form was therefore not able to determine what the resident's sleep patterns and behaviours were in order to identify the risks associated with bed rail use. The BRA form identified the resident with several risk factors associated with the potential for bed rail associated injury such as poor cognition, balance and trunk control issues and was on medication that required safety precautions. The resident's plan of care included that the resident had weakness on one side. This was not included in the BRA. The conclusion was that the resident would use both bed rails for turning and positioning. No documentation was available to establish what safety risks were identified, if any with bed rails applied. 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 in 2017, and no information was available to determine if alternatives were considered, and if so, which alternatives were trialled, when and if effective.

Resident #002 was observed to be in bed at the time of inspection with both quarter length bed rails elevated. No staff were present. The resident was admitted in 2015 and clinically assessed two days post admission to require extensive assistance with bed mobility. According to the resident's current written plan of care, both quarter bed rails were required only during times when staff assisted the resident with bed mobility, and left down or not applied when staff left the room. The plan of care included that the resident had cognitive loss and judgment issues, poor balance and a history of falls from bed. The BRA form completed in April 2017, included that the resident could not use the bed rails independently for bed mobility, the "level of confusion" section was blank, and identified that the resident was cognitively aware and chose to use the bed rails (in contradiction to the plan of care and other sections of the BRA).

Resident #003 was observed in bed with both quarter bed rails elevated or applied at the time of inspection. The resident was admitted in 2012, and their written plan of care did not include any bed mobility information or bed rail use information until July 2016. At that time, the only information included "one to two staff assistance". In November 2016, the resident required extensive assistance by staff to reposition while in bed. This was preceded by the completion of the BRA form dated earlier in November 2016, identifying that the resident was not to use bed rails due to risk factors associated with entrapment risk. The assessor identified that the resident was at risk of climbing over the bed rails, was not cognitively aware, was always disoriented, had balance issues, did not use the bed rails independently and had a history of falls from bed. As interventions, the resident was provided with a bed alarm and a falls prevention mat on the floor beside the bed to mitigate risk of injury from any falls in November 2016. In January 2017, the resident fell from bed and despite the level of risk associated with bed rails being applied, the substitute decision maker (SDM) insisted that bed rails be re-applied. The registered staff agreed without conducting a full assessment as required. The BRA dated January 2017, was incomplete and no alternatives were listed on the form to determine if any other interventions or alternatives were trialled before selecting the bed rails, such as soft rails or adjustable side bolsters. If bolsters were not effective, and the registered staff felt that bed rails would benefit the resident, the entrapment risk would need to be mitigated by including bed accessories designed for the specific entrapment risk.

The conclusions in the assessment dated in early November 2016, were not comprehensive and did not describe the specific entrapment risk associated with the resident's bed rail.

Resident #004 was observed in bed at the time of inspection with both quarter bed rails elevated. The resident was admitted in 2014, and no information was listed in the written plan of care about their bed rail use. When re-assessed in 2016, the resident required extensive assistance to roll side to side. The residents written plan of care dated December 2016, included two quarter bed rails to assist with bed mobility. The plan of care also identified the resident at risk of falling out of bed and included interventions such as mats on the floor. The resident's BRA form dated December 2016, was not fully completed. No information was documented under the section titled "Medical" which included questions related to risk factors such as involuntary movements, medication use, balance and falls history. The BRA form included that the resident was cognitively aware and chose to use the bed rails, for bed mobility. Under the "Loss of Confusion" section, the assessor identified that the resident was "always disoriented" and that the rails could only be used with staff supervision. The conclusion included that the resident was "cognitively intact and can ask to have rails up or down". The overall assessment was confusing and did not align with the plan of care. The risks associated with having bed rails applied were not clear and it was not clear if the resident could actually use the bed rails independently.

C) The policy provided at the time of inspection had not been amended as required in the order issued on August 10, 2016. The policy was missing staff roles and responsibilities in assessing residents who use one or more bed rails, details of the assessment process (how long residents monitored with bed rails, without bed rails, with alternatives in place), forms to be used, considerations for or against bed rail application, bed rail use risk factors, alternatives available for the replacement of bed rails, interventions available to mitigate any identified risks (i.e. padding on bed rails if bruising noted), the role of the SDM and resident in selecting the appropriate device for bed mobility, the information required to be provided to residents and SDMs, when consent for use of bed rails is required, when staff are to report bed system issues to maintenance, how registered staff are made aware of the bed entrapment status of each bed where bed rails would be applied, who evaluates the beds, how often and the procedures used and any additional applicable details necessary to ensure registered and non-registered staff involved in the process are required to have in order to fully understand and perform their duties.

D) The Director of Care identified that a brochure or pamphlet titled "A Guide to Bed Safety", was mailed out to all families/SDMs in August 2016. The pamphlet was acquired from the United States Food and Drug Administration and it included bed rail use risks and benefits, how to reduce risks, role of the SDM or family, alternatives to bed rails, bed safety statistics and contact information for citizens of the United States. The pamphlet was not customized to reflect Canadian related statistics and Health Canada contact information. The details in the order required the licensee to identify the regulations that govern hospital beds in Ontario and the prevailing practices used in Ontario (Health Canada's "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" and the two associated companion guides), how beds pass or fail entrapment zone testing and other relevant facts associated with bed systems and the use of bed rails.

The licensee therefore did not assess all residents in accordance with the prevailing practices or as specified in the order and the policy and educational material was not developed or amended as specified in the order.

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 Ontario Regulation 79/10, the scope of the non-compliance is pattern, as more than one of the residents who used one or more bed rails was not 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 non-compliance is on-going as an order was previously issued on August 10, 2016.

(120)

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

Oct 31, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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 11 day of August 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

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

Service Area Office /
Bureau régional de services : Hamilton