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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Jun 8, 2016	2016_189120_0036	024144-15	Follow up

Licensee/Titulaire de permis

PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE
72 Town Centre Drive Townsend ON N0A 1S0

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

GARDENVIEW LONG TERM CARE HOME
72 Town Centre Drive Townsend ON N0A 1S0

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 26, 27, 2016

An inspection (2015-344586-0013) was previously conducted in July 2015 at which time non compliance (Order #001) was identified related to the licensee's bed safety program. For this follow-up inspection, the conditions that were laid out in the Order have not been fully met and the Order remains outstanding.

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

During the course of the inspection, the inspector toured both floors of the home, observed residents' bed systems and reviewed resident clinical records related to bed safety assessments and bed rail use.

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

According to prevailing practices tilted "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), all residents who use one or more bed rails are to be evaluated by an interdisciplinary team, over a period of time while in bed to determine safety risks associated with bed rail use. To guide the assessor, a series of questions would be completed to determine whether the bed rail(s) are a safe device for residents while fully awake or while they are asleep. The guideline also emphasizes the need to document clearly whether alternative interventions were trialled before bed rails were implemented and if the interventions were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, cognition, behaviours, medication use, mobility and any involuntary movements, falls risks, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed), environmental factors and the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or their Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to 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.

A) The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified in the above guideline. According to the Director of Care, the questionnaire used by herself and her registered staff included a form titled "Bed Rail Risk Assessment" which was completed electronically (Point Click Care) for each resident. Verification was made that the "Bed Rail Risk Assessment form" was completed for all residents, however the questions and processes identified in the prevailing practices identified above were not fully incorporated into the process. The assessment did not include many of the questions and practices identified in the above noted guideline related to the hazards associated with bed rail use such as suspension, entanglement, strangulation, suffocation, entrapment (regardless if the bed passed or failed all zones of entrapment), sleeping habits or bodily injury against the rail or other bed components. The questions were related to bed rail use for repositioning while in bed and their overall mobility, their falls history and cognition which provided a partial assessment. The assessment questions did not provide any direction to registered staff when the questions were answered with either a "yes" or a "no". The assessment did not include information about how long the resident was monitored for while in bed to determine sleeping patterns and habits, what alternatives were trialled before applying one or more bed rails or what interdisciplinary team members were involved in the decision making.

The written plan of care was reviewed for residents on the 1st floor after observing on May 26, 2016 one bed rail in the guard position on beds in 12 identified rooms. Most beds also had the opposite bed rail in the transfer or assist position. The bed rail observed to be in the guard position was on the window side of each bed and in some cases covered by a blanket. No residents were observed in the beds at the time of observation. According to the written plan of care for residents in 6 of the identified 12 rooms, the same conclusion was documented for each resident regarding their bed rail use. No information was available regarding the need to have a bed rail in the transfer position for self assistance in and out of their beds. Each stated that they required 2 bed rails down or in the guard position while in bed. Some did not provide a reason as to why the bed rails were required, however under a different task titled "bed mobility", each resident was identified to require the assistance of 2 staff to turn or reposition while in bed. It was not clear whether the resident could in fact turn and reposition themselves while in bed and use their bed rail independently or if the bed rails would only serve a purpose during times when staff were assisting the resident to turn or reposition and would then be rotated out of the way and below the level of the mattress.

According to staff interviewed and the Director of Care, no formal training with respect to bed system hazards and applicable use of bed rails was provided. Based on observations, staff had access to the written plan of care for each resident but continued to apply bed rails when the plan of care for each resident clearly identified that the residents in the rooms noted above were to only have bed rails applied "while in bed". Failure of staff to follow the the directives regarding medical devices can lead to injury.

B) On May 27, 2016, the majority of the beds on the first floor were observed to be lowered to the lowest position and the rotating assist rails were not in either the transfer or the guard position, but partially rotated back and resting on the floor. The position of the bed prevented the bed rails from being rotated out of the way and below the level of the mattress. Concerns were raised regarding the position of the bed rails possibly causing entrapment for those residents who were at high risk of entrapment. According to staff working in this home area, the beds were lowered to prevent injuries to residents from falling out of the bed once they crawled independently back into them throughout the day. This was in response to several wandering residents who liked to go into other rooms and climb into another resident's beds. The written plan of care was reviewed for those same residents identified above, to determine direction related to bed position. Only one resident's plan of care identified that their bed was to remain in the lowest position throughout the day. All of the others identified that their bed be placed in the low position while the resident was in bed. However, neither the plan of care or the assessment addressed how the bed rails would be used while the bed was in the lowest position if not in the guard or transfer position.

According to the manufacturer's use instructions for the beds in the home and according to the supplier and repair contractor for the bed systems in the home, the bed systems were not to be left in the lowest position once the bed was unoccupied and that the level of the bed was to be adjusted to the sitting comfort of each individual resident. Once a resident was in the bed, the bed could be lowered to the lowest position if it was assessed that the resident was at a risk of falls. A bed rail, if required while in the lowest position would need to be exchanged for a different style called a "quarter rail". This type of rail raises and lowers and does not rotate and therefore would not be resting on the floor. Therefore, each resident's bed and their individual needs would need to be assessed to determine if the style of the bed rail was appropriate for their circumstances. This was not included in the original assessment. [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 9th day of June, 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_0036
Log No. / Registre no:	024144-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 8, 2016
Licensee / Titulaire de permis :	PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE 72 Town Centre Drive, Townsend, ON, N0A-1S0
LTC Home / Foyer de SLD :	GARDENVIEW LONG TERM CARE HOME 72 Town Centre Drive, Townsend, ON, N0A-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARA DI BIASE

To PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE, 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: 2015_344586_0013, 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 ensure that the following is completed:

1. Amend or re-develop the home's current bed rail use assessment form to include bed system safety questions and processes contained in the prevailing practices document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". The form shall guide the assessor in deciding if one or more bed rails and the type of bed rail is or will be a viable and safe option for the resident after bed rail alternatives have been trialled.
2. Re-assess all residents who use one or more bed rails by applying the amended or re-developed bed system safety questionnaire and process. Document the results, alternatives trialled and the names of the persons who participated in the re-assessments.
3. Update the resident's written plan of care with the outcome of the re-assessments. Include when a bed rail (medical device) is to be applied, type or size, how many and on what side of the resident and why.
4. Bed safety education shall be provided to all staff who provide care to residents. The education at a minimum shall include information related to bed entrapment zones 1-4 and their hazards, when to apply bed rails, how staff will be informed if changes to the resident's status for bed rails changes, how to recognize when the bed system is unsafe, how to recognize when a resident's condition changes with respect to bed rail use, how and when to report bed safety concerns, how residents are assessed for bed rail use and how and when to apply any entrapment zone interventions if necessary.
5. Develop a policy and procedure identifying the roles and responsibilities of various staff members and departments in ensuring that bed systems are maintained in good condition and evaluated for entrapment and that the residents are assessed regularly for bed rail use and bed rail safety.

Grounds / Motifs :

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

According to prevailing practices tilted "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), all residents who use one or more bed rails are to be evaluated by an interdisciplinary team, over a period of time while in bed to

determine safety risks associated with bed rail use. To guide the assessor, a series of questions would be completed to determine whether the bed rail(s) are a safe device for residents while fully awake or while they are asleep. The guideline also emphasizes the need to document clearly whether alternative interventions were trialled before bed rails were implemented and if the interventions were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, cognition, behaviours, medication use, mobility and any involuntary movements, falls risks, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed), environmental factors and the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or their Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to 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.

A) The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified in the above guideline. According to the Director of Care, the questionnaire used by herself and her registered staff included a form titled "Bed Rail Risk Assessment" which was completed electronically (Point Click Care) for each resident. Verification was made that the "Bed Rail Risk Assessment form" was completed for all residents, however the questions and processes identified in the prevailing practices identified above were not fully incorporated into the process. The assessment did not include many of the questions and practices identified in the above noted guideline related to the hazards associated with bed rail use such as suspension, entanglement, strangulation, suffocation, entrapment (regardless if the bed passed or failed all zones of entrapment), sleeping habits or bodily injury against the rail or other bed components. The questions were related to bed rail use for repositioning while in bed and their overall mobility, their falls history and cognition which provided a partial assessment. The assessment questions did not provide any direction to registered staff when the questions were answered with either a "yes" or a "no". The assessment did not include information about how long the resident was monitored for while in bed to determine sleeping patterns and

habits, what alternatives were trialled before applying one or more bed rails or what interdisciplinary team members were involved in the decision making.

The written plan of care was reviewed for residents on the 1st floor after observing on May 26, 2016 one bed rail in the guard position on beds in 12 identified rooms. Most beds also had the opposite bed rail in the transfer or assist position. The bed rail observed to be in the guard position was on the window side of each bed and in some cases covered by a blanket. No residents were observed in the beds at the time of observation. According to the written plan of care for residents in 6 of the identified 12 rooms, the same conclusion was documented for each resident regarding their bed rail use. No information was available regarding the need to have a bed rail in the transfer position for self assistance in and out of their beds. Each stated that they required 2 bed rails down or in the guard position while in bed. Some did not provide a reason as to why the bed rails were required, however under a different task titled "bed mobility", each resident was identified to require the assistance of 2 staff to turn or reposition while in bed. It was not clear whether the resident could in fact turn and reposition themselves while in bed and use their bed rail independently or if the bed rails would only serve a purpose during times when staff were assisting the resident to turn or reposition and would then be rotated out of the way and below the level of the mattress.

According to staff interviewed and the Director of Care, no formal training with respect to bed system hazards and applicable use of bed rails was provided. Based on observations, staff had access to the written plan of care for each resident but continued to apply bed rails when the plan of care for each resident clearly identified that the residents in the rooms noted above were to only have bed rails applied "while in bed". Failure of staff to follow the the directives regarding medical devices can lead to injury.

B) On May 27, 2016, the majority of the beds on the first floor were observed to be lowered to the lowest position and the rotating assist rails were not in either the transfer or the guard position, but partially rotated back and resting on the floor. The position of the bed prevented the bed rails from being rotated out of the way and below the level of the mattress. Concerns were raised regarding the position of the bed rails possibly causing entrapment for those residents who were at high risk of entrapment. According to staff working in this home area, the beds were lowered to prevent injuries to residents from falling out of the bed once they crawled independently back into them throughout the day. This was

in response to several wandering residents who liked to go into other rooms and climb into another resident's beds. The written plan of care was reviewed for those same residents identified above, to determine direction related to bed position. Only one resident's plan of care identified that their bed was to remain in the lowest position throughout the day. All of the others identified that their bed be placed in the low position while the resident was in bed. However, neither the plan of care or the assessment addressed how the bed rails would be used while the bed was in the lowest position if not in the guard or transfer position.

According to the manufacturer's use instructions for the beds in the home and according to the supplier and repair contractor for the bed systems in the home, the bed systems were not to be left in the lowest position once the bed was unoccupied and that the level of the bed was to be adjusted to the sitting comfort of each individual resident. Once a resident was in the bed, the bed could be lowered to the lowest position if it was assessed that the resident was at a risk of falls. A bed rail, if required while in the lowest position would need to be exchanged for a different style called a "quarter rail". This type of rail raises and lowers and does not rotate and therefore would not be resting on the floor. Therefore, each resident's bed and their individual needs would need to be assessed to determine if the style of the bed rail was appropriate for their circumstances. This was not included in the original assessment (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 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 8th day of June, 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