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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 16, 2018	2018_539120_0034	007675-18	Follow up

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Brampton
7891 McLaughlin Road BRAMPTON ON L6Y 5H8

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): July 12 and August 1, 2018

A follow up inspection (2018-539120-0006) was previously conducted on February 1, 2018, in response to a Compliance Order related to bed safety issued on July 25, 2017. For this follow-up inspection, the requirements in the Compliance Order were met, however additional findings under s. 15 related to bed safety were identified. See below for details.

During the course of the inspection, the inspector(s) spoke with the administrator, maintenance person, a registered nurse and a resident.

During the course of the inspection, the inspector toured various home areas, observed resident bed systems, reviewed resident clinical records and policies and procedures related to bed safety.

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 failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The Director of the Ministry of Health and Long Term Care sent a Memorandum to all long term care home administrators on August 12, 2012, identifying a specific document from Health Canada titled 'Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards (2008)". The Ministry expected the administrators to follow the recommendations in the document to reduce or mitigate the risk of bed-related hazards. Included in the Health Canada guidelines, is the title of a companion guide which provides specific guidance in mitigating certain risks associated with bed systems entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment".

Three previous inspections were made, one in November 2016, a follow up inspection on July 4, 2017, and another follow up inspection on February 1, 2018. The latest follow up inspection (2018-539120-0006), resulted in the issuance of a Compliance Order (CO) on April 5, 2018, for a compliance date of June 29, 2018. The CO included multiple requirements related to the licensee's bed safety related policies and procedures, clinical assessment forms, assessment process, and staff education in being able to assess the resident in accordance with bed safety related prevailing practices.

During this follow up inspection on July 12 and August 1, 2018, the conditions that were laid out in the previous CO #001 from inspection report 2018-539120-0006 were

reviewed and included the following:

1. Re-assess all residents who were admitted prior to July 25, 2017, and who were provided with one or more bed rails, using the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings". (U.S. F.D.A, April 2003) which is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006". The assessment shall, at a minimum, include a process whereby the resident was assessed for;
a. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period; and
b. safety risks associated with the bed rail, if applied and deemed necessary where an alternative was not successful, while the resident is asleep for a specific period of time.

2. All registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply the expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006", and the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

3. Amend the current "Bedrail Minimization and Risk Reduction" policy RC-10-01-10, dated September 2017, to include additional and 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", related to the identification of risk factors associated with bed rail use. 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) 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; and
c) alternatives available for the replacement of bed rails; and
d) interventions available for the resident that are used in conjunction with a bed rail; and

e) the role of the Substitute Decision Maker (SDM) and resident in selecting the appropriate device for bed mobility; and
f) additional information on the role and responsibilities of the personal support worker who is involved in observing residents for risks related to the use of one or more bed rails.

4. Update the written plan of care for those residents where changes were identified after re-assessing each resident who uses one or more bed rails, using a resident clinical assessment form and/or process related to safety risks.

Residents previously identified during the previous inspection conducted on February 1, 2018, as inadequately assessed for risk and who had bed rails in use without appropriate interventions were verified during this follow-up inspection to have been re-assessed and risks mitigated. Each of the five residents had their bed rails removed as they were not required. The other requirements listed above were all met, with the exception of point #3, which is explained below. During this inspection, other residents were randomly selected in order to determine if they were assessed for bed safety risks where bed rails were in use or applied, and if risks were identified, what course of action or steps were taken to mitigate the risks.

The home's policy, entitled "Bed Rail Minimization and Risk Reduction" (RC-08-01-09) dated April 2017, included the requirement for registered staff to complete Appendix 3, which was a form entitled "Bedrail and Entrapment Risk Assessment (BRERA)". The BRERA form was to be used to "assess the resident's situation looking for possible risk factors related to the use of bed rails" and that "all alternative measures to promote resident safety be assessed and considered prior to the use of bed rails". However, the policy did not include what steps or interventions to take when entrapment risks were identified.

Resident #104 and #101 were both re-assessed by registered staff member #201 for bed safety risks within the last two months. Each of their assessments were reviewed in detail with staff #201 on August 1, 2018. Both residents historically had one or more bed rails applied and who did not benefit greatly from their use. When re-assessed, each resident was identified to have risk factors associated with increased risk of entrapment and other bed related risks. Some of the factors included impaired cognition, unable to understand or effectively use the call bell system and physical limitations with transfers and bed mobility. Additionally, each resident was observed over a three-night period for any observed bed related risks while sleeping. Resident #104 was noted to have

excessive movement while in bed, placing them at greater risk of entrapment. Resident #101 did not move in bed, and no specific risks were seen, but had a therapeutic mattress that did not pass three zones of entrapment. In each case, the resident was not able to make any decisions for themselves about the risks associated with their bed rails and staff #201 therefore deferred to each of their substitute decision makers (SDM). According to staff #201, each SDM received information about the risks of continued bed rail use and were informed about the alternatives that were available. These included removing the bed rail, placing the bed in the lowest position, replacing the mattress with one that had a raised edge, a falls injury prevention accessory on each side of the bed, bed alarm, a perimeter bolster, reaching pole or a different style of bed and bed rail. In each case, the SDM did not agree to have the bed rail replaced with an alternative option and staff #201 left the bed rail(s) in place and had the SDM sign a "Negotiated Risk Agreement" form. The form was to be used when "a resident's choice was contrary to the recommendations of the interdisciplinary team" and "did not constitute a waiver of liability". The policy (RC-05-01-04) associated with the use of the form did not include any reference to bed systems specifically and included that "the negotiated risk process provided a vehicle to ensure that all elements of the resident's right to make a decision which put them at risk were documented".

For resident #104, the negotiated risk agreement form signed by the SDM in June 2018, included documentation that the resident was at risk of entrapment of a body part, but did not include what alternatives were trialled to decrease the risk. Interventions to decrease injuries related to falling was included. The resident's BRERA dated July 2018, included that they were at risk for entrapment and what alternatives were available and suggested to the SDM and subsequently why the SDM refused. The resident's sleep observation data from May 2018, included bed system related concerns. When the resident was observed in bed during the inspection with two bed rails were observed in an identified position and both included an accessory to prevent injury. A falls prevention accessory was in place, however the bed, even when in the lowest position was greater than 10 inches above the floor. According to staff #201, the SDM refused to have any accessories applied in place of the bed rails or other alternatives related to the bed system. Staff #201 was asked how many accessories were available in the home, and they said only one type. The type was identified by staff to be inappropriate for single width bed mattresses. Staff #201 was informed that the accessories were available in different sizes and shapes from various suppliers. Staff #201 reported that they did not know what other steps could be taken to intervene when the SDM refused to have the bed rails removed and said that they followed their "Bed Rail Minimization Algorithm". The Alogrithm included guidance that if consent to remove the bed rails was not

obtained, that staff were to determine the effect of the bed rails. If the bed rails had a restraining effect, then they were to implement their restraint policy. If the bed rails were to be used based only on resident or SDM request, then care plan strategies to promote resident safety were to be implemented. The resident's most recent care plan included that the bed rails were restraints and the strategy included the need for staff to monitor the resident every hour. No strategies were included to address the risk of entrapment or suspension. Staff #201 was aware that a bed with a specific type of bed rail in an identified position on a bed with a resident who could roll or slip off the edge of their bed, could easily have a portion of their body trapped behind the bed rail while another portion of their body fell to the floor, thereby being suspended. None of the clinical documents provided included or mentioned suspension risks. Steps taken to prevent resident entrapment or suspension were not included with the exception of increased monitoring, a strategy that alone, does not prevent entrapment or suspension.

For resident #101, the negotiated risk agreement form signed by the SDM in July 2018, included documentation that the resident was at risk of entrapment of a body part, especially if their therapeutic surface malfunctioned but did not include what alternatives were trialled to decrease the risk. Interventions to decrease injuries related to falling were included. The resident's BRERA dated July 2018, included what alternatives were available and suggested to the SDM and subsequently why the SDM refused. When the resident was observed in bed during the inspection with two bed rails were in the raised position and included an accessory to prevent injury. The resident was also on a therapeutic mattress that was not evaluated for entrapment zones 2, 3 and 4, as confirmed by the maintenance person on August 1, 2018. The maintenance person stated that due to the soft nature of the therapeutic mattress, it would not have passed entrapment testing. Falls injury prevention accessories were not seen and the bed was not in it's lowest position and no accessories were used to mitigate the gaps between the mattress and the bed rail. However, when the resident was seen in bed during the inspection, a bed rail accessory was seen loosely fitted between the mattress and bed rail. The bed rail accessory was not effective in minimizing the gaps. According to staff #201, the SDM refused to have accessories applied in place of the bed rails and stated that they took up too much space on the bed. Staff #201 reported that they did not know what other steps could be taken to intervene when the SDM refused to have the bed rails used only during staff supervision when care was being provided. The resident's rails were therefore deemed as restraints and their care plan was updated to include that care staff monitor the resident every hour. Steps taken to prevent resident entrapment were not included with the exception of increased monitoring, a strategy alone, that does not prevent entrapment.

Resident #103 was observed in bed during the inspection with two raised bed rails and on a therapeutic mattress that was not evaluated for entrapment zones 2, 3 and 4, as confirmed by the maintenance person on August 1, 2018. No accessories were provided for the gaps between the bed rail and mattress. The bed was not in the lowest position as per the resident's most recent plan of care. According to the resident's BRERA completed in June 2018, the resident had physical limitations thereby increasing their risk of entrapment, but no risks were identified during a three-night sleep observation period in May 2018. The resident, when interviewed during the inspection, stated that they used their bed rails for bed mobility. The resident chose not to trial any alternatives. Staff #201 therefore deemed the bed rails as restraints and assigned care staff to monitor the resident hourly. The resident was provided with a negotiated risk form which was signed in June 2018. Steps taken to prevent resident entrapment were not included with the exception of increased monitoring, a strategy alone that does not prevent entrapment.

The licensee provided a policy entitled "Bed Rail Minimization and Risk Reduction" policy RC-10-01-10, dated September 2017, during the follow up inspection in February 2018. However, during this inspection, staff #201 could not find it in their corporate database. Staff #201 confirmed that a policy dated April 2017, with a policy number of RC-08-01-09 with the same title was used to guide them when they completed the resident assessments. This policy was reviewed and also failed to include the following previously identified information;

a) details of the process of assessing residents for bed rail need and safety upon admission, and/or when a change in the resident's condition has been identified; and
f) additional information on the role and responsibilities of the personal support worker who is involved in observing residents for risks related to the use of one or more bed rails.

Staff #201 however provided a document entitled "Tip Sheet for Bed Safety Roll Out", which included detailed information and guidance in completing resident assessments related to bed safety and included the role of the personal support worker and details about the home's sleep observation process for residents upon admission and/or when bed rails have been added. [s. 15. (1) (b)]

Additional Required Actions:

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

Issued on this 17th day of September, 2018

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 :	2018_539120_0034
Log No. / No de registre :	007675-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 16, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Brampton 7891 McLaughlin Road, BRAMPTON, ON, L6Y-5H8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Hannah Oksemberg

To Extendicare (Canada) Inc., 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: 2018_539120_0006, CO #001;

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 15(1)(b)

The licensee shall complete the following:

1. Resident #101 and #103, and any other resident who has been equipped with a soft therapeutic mattress, uses one or more bed rails and has been assessed to have risks for entrapment, shall have an accessory placed between all bed rails and the mattress to mitigate possible body part entrapment in zones 2, 3 and 4. The use of the accessory shall be monitored and added to the resident's plan of care.

2. Resident #104, and any other residents who have been assessed to be at risk of injury, suspension or entrapment with the application of one or more quarter length bed rails (that move up and down) or rotating assist rails (that rotate 180 degrees) shall be provided with a bed system and/or accessories according to the resident's assessed safety needs.

3. The licensee's policy entitled "Bed Rail Minimization and Risk Reduction" (RC-08-01-09) dated April 2017", shall be amended to include what accessories and/or alternatives are available to reduce a resident's risk of entrapment or suspension as per but not limited to Health Canada's companion guide entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment".

4. All registered staff who complete resident bed safety assessments shall be made aware of the available accessories and/or alternatives to reduce risk of entrapment or suspension as per but not limited to Health Canada's companion guide entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". The accessories or intervention shall be included on the resident's plan of care.

Grounds / Motifs :

1. 1. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The Director of the Ministry of Health and Long Term Care sent a Memorandum to all long term care home administrators on August 12, 2012, identifying a specific document from Health Canada titled 'Adult Hospital Beds: Patient

Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards (2008)". The Ministry expected the administrators to follow the recommendations in the document to reduce or mitigate the risk of bed-related hazards. Included in the Health Canada guidelines, is the title of a companion guide which provides specific guidance in mitigating certain risks associated with bed systems entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment".

Three previous inspections were made, one in November 2016, a follow up inspection on July 4, 2017, and another follow up inspection on February 1, 2018. The latest follow up inspection (2018-539120-0006), resulted in the issuance of a Compliance Order (CO) on April 5, 2018, for a compliance date of June 29, 2018. The CO included multiple requirements related to the licensee's bed safety related policies and procedures, clinical assessment forms, assessment process, and staff education in being able to assess the resident in accordance with bed safety related prevailing practices.

During this follow up inspection on July 12 and August 1, 2018, the conditions that were laid out in the previous CO #001 from inspection report 2018-539120-0006 were reviewed and included the following:

1. Re-assess all residents who were admitted prior to July 25, 2017, and who were provided with one or more bed rails, using the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings". (U.S. F.D.A, April 2003) which is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006". The assessment shall, at a minimum, include a process whereby the resident was assessed for;
a. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period; and
b. safety risks associated with the bed rail, if applied and deemed necessary where an alternative was not successful, while the resident is asleep for a specific period of time.

2. All registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply the

expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006", and the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

3. Amend the current "Bedrail Minimization and Risk Reduction" policy RC-10-01-10, dated September 2017, to include additional and 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", related to the identification of risk factors associated with bed rail use. 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) 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; and
c) alternatives available for the replacement of bed rails; and
d) interventions available for the resident that are used in conjunction with a bed rail; and
e) the role of the Substitute Decision Maker (SDM) and resident in selecting the appropriate device for bed mobility; and
f) additional information on the role and responsibilities of the personal support worker who is involved in observing residents for risks related to the use of one or more bed rails.

4. Update the written plan of care for those residents where changes were identified after re-assessing each resident who uses one or more bed rails, using a resident clinical assessment form and/or process related to safety risks.

Residents previously identified during the previous inspection conducted on February 1, 2018, as inadequately assessed for risk and who had bed rails in use without appropriate interventions were verified during this follow-up

inspection to have been re-assessed and risks mitigated. Each of the five residents had their bed rails removed as they were not required. The other requirements listed above were all met, with the exception of point #3, which is explained below. During this inspection, other residents were randomly selected in order to determine if they were assessed for bed safety risks where bed rails were in use or applied, and if risks were identified, what course of action or steps were taken to mitigate the risks.

The home's policy, entitled "Bed Rail Minimization and Risk Reduction" (RC-08-01-09) dated April 2017, included the requirement for registered staff to complete Appendix 3, which was a form entitled "Bedrail and Entrapment Risk Assessment (BRERA)". The BRERA form was to be used to "assess the resident's situation looking for possible risk factors related to the use of bed rails" and that "all alternative measures to promote resident safety be assessed and considered prior to the use of bed rails". However, the policy did not include what steps or interventions to take when entrapment risks were identified.

Resident #104 and #101 were both re-assessed by registered staff member #201 for bed safety risks within the last two months. Each of their assessments were reviewed in detail with staff #201 on August 1, 2018. Both residents historically had one or more bed rails applied and who did not benefit greatly from their use. When re-assessed, each resident was identified to have risk factors associated with increased risk of entrapment and other bed related risks. Some of the factors included impaired cognition, unable to understand or effectively use the call bell system and physical limitations with transfers and bed mobility. Additionally, each resident was observed over a three-night period for any observed bed related risks while sleeping. Resident #104 was noted to have excessive movement while in bed, placing them at greater risk of entrapment. Resident #101 did not move in bed, and no specific risks were seen, but had a therapeutic mattress that did not pass three zones of entrapment. In each case, the resident was not able to make any decisions for themselves about the risks associated with their bed rails and staff #201 therefore deferred to each of their substitute decision makers (SDM). According to staff #201, each SDM received information about the risks of continued bed rail use and were informed about the alternatives that were available. These included removing the bed rail, placing the bed in the lowest position, replacing the mattress with one that had a raised edge, a falls injury prevention accessory, bed alarm, a perimeter bolster, reaching pole or a different style of bed and bed rail. In each case, the SDM did not agree to have the bed rail replaced with an

alternative option and staff #201 left the bed rail(s) in place and had the SDM sign a "Negotiated Risk Agreement" form. The form was to be used when "a resident's choice was contrary to the recommendations of the interdisciplinary team" and "did not constitute a waiver of liability". The policy (RC-05-01-04) associated with the use of the form did not include any reference to bed systems specifically and included that "the negotiated risk process provided a vehicle to ensure that all elements of the resident's right to make a decision which put them at risk were documented".

For resident #104, the negotiated risk agreement form signed by the SDM in June 2018, included documentation that the resident was at risk of entrapment of a body part, but did not include what alternatives were trialled to decrease the risk. Interventions to decrease injuries related to falling was included. The resident's BRERA dated July 2018, included that they were at risk for entrapment and what alternatives were available and suggested to the SDM and subsequently why the SDM refused. The resident's sleep observation data from May 2018, included bed system related concerns. When the resident was observed in bed on July 12, 2018, two bed rails were observed in an identified position and both included an accessory to prevent injury. A falls prevention accessory was in place, however the bed, even when in the lowest position was greater than 10 inches above the floor. According to staff #201, the SDM refused to have any accessories applied in place of the bed rails or other alternatives related to the bed system. Staff #201 was asked how many accessories were available in the home, and they said only one type. The type was identified by staff to be inappropriate for single width bed mattresses. Staff #201 was informed that the accessories were available in different sizes and shapes from various suppliers. Staff #201 reported that they did not know what other steps could be taken to intervene when the SDM refused to have the bed rails removed and said that they followed their "Bed Rail Minimization Algorithm". The Alogrithm included guidance that if consent to remove the bed rails was not obtained, that staff were to determine the effect of the bed rails. If the bed rails had a restraining effect, then they were to implement their restraint policy. If the bed rails were to be used based only on resident or SDM request, then care plan strategies to promote resident safety were to be implemented. The resident's most recent care plan included that the bed rails were restraints and the strategy included the need for staff to monitor the resident every hour. No strategies were included to address the risk of entrapment or suspension. Staff #201 was aware that a bed with a specific type of bed rail in an identified position on a bed with a resident who could roll or slip off the edge of their bed, could easily have a

portion of their body trapped behind the bed rail while another portion of their body fell to the floor, thereby being suspended. None of the clinical documents provided included or mentioned suspension risks. Steps taken to prevent resident entrapment or suspension were not included with the exception of increased monitoring, a strategy that alone, does not prevent entrapment or suspension.

For resident #101, the negotiated risk agreement form signed by the SDM in July 2018, included documentation that the resident was at risk of entrapment of a body part, especially if their therapeutic surface malfunctioned but did not include what alternatives were trialled to decrease the risk. Interventions to decrease injuries related to falling were included. The resident's BRERA dated July 2018, included what alternatives were available and suggested to the SDM and subsequently why the SDM refused. When the resident was observed in bed he inspection with two bed rails were in the raised position and included an accessory to prevent injury. The resident was also on a therapeutic mattress that was not evaluated for entrapment zones 2, 3 and 4, as confirmed by the maintenance person on August 1, 2018. The maintenance person stated that due to the soft nature of the therapeutic mattress, it would not have passed entrapment testing. Falls injury prevention accessories were not seen and the bed was not in it's lowest position and no accessories were used to mitigate the gaps between the mattress and the bed rail. However, when the resident was seen in bed on August 1, 2018, a bed rail accessory was seen loosely fitted between the mattress and bed rail. The bed rail accessory was not effective in minimizing the gaps. According to staff #201, the SDM refused to have accessories applied in place of the bed rails and stated that they took up too much space on the bed. Staff #201 reported that they did not know what other steps could be taken to intervene when the SDM refused to have the bed rails used only during staff supervision when care was being provided. The resident's rails were therefore deemed as restraints and their care plan was updated to include that care staff monitor the resident every hour. Steps taken to prevent resident entrapment were not included with the exception of increased monitoring, a strategy alone, that does not prevent entrapment.

Resident #103 was observed in bed during the inspection with two raised bed rails and on a therapeutic mattress that was not evaluated for entrapment zones 2, 3 and 4, as confirmed by the maintenance person on August 1, 2018. No accessories were provided for the gaps between the bed rail and mattress. The

bed was not in the lowest position as per the resident's most recent plan of care. According to the resident's BRERA completed in June 2018, the resident had physical limitations thereby increasing their risk of entrapment, but no risks were identified during a three-night sleep observation period in May 2018. The resident, when interviewed during the inspection, stated that they used their bed rails for bed mobility. The resident chose not to trial any alternatives. Staff #201 therefore deemed the bed rails as restraints and assigned care staff to monitor the resident hourly. The resident was provided with a negotiated risk form which was signed in June 2018. Steps taken to prevent resident entrapment were not included with the exception of increased monitoring, a strategy alone that does not prevent entrapment.

The licensee provided a policy entitled "Bed Rail Minimization and Risk Reduction" policy RC-10-01-10, dated September 2017, during the follow up inspection in February 2018. However, during this inspection, staff #201 could not find it in their corporate database. Staff #201 confirmed that a policy dated April 2017, with a policy number of RC-08-01-09 with the same title was used to guide them when they completed the resident assessments. This policy was reviewed and also failed to include the following previously identified information;

a) details of the process of assessing residents for bed rail need and safety upon admission, and/or when a change in the resident's condition has been identified; and
f) additional information on the role and responsibilities of the personal support worker who is involved in observing residents for risks related to the use of one or more bed rails.

Staff #201 however provided a document entitled "Tip Sheet for Bed Safety Roll Out", which included detailed information and guidance in completing resident assessments related to bed safety and included the role of the personal support worker and details about the home's sleep observation process for residents upon admission and/or when bed rails have been added.

This Compliance Order is based upon three factors where there has been a finding of non-compliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope (pervasiveness), severity (of the harm or risk of harm) and history of non-compliance. In relation to s. 15(1)(b) of O. Reg. 79/10, the severity of the issue was determined to be a level 2, as the non-compliance had

the potential to cause harm to residents. The scope of the issue was determined to be a level 3 (widespread) as three out of three residents were assessed to have bed safety related risks. The home had a level 4 history of on-going noncompliance with this section of the Regulation that included:
* A compliance order (CO) #002 issued on December 14, 2016, with a compliance due date of March 15, 2017 (2016-553536-0021)
* A compliance order (CO) #001 issued on July 25, 2017, with a compliance due date of December 29, 2017 (2017-539120-0042)
* A compliance order (CO) #001 issued on April 5, 2018, with a compliance due date of June 29, 2018 (2018-539120-0006)
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 21, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

Service Area Office /
Bureau régional de services : Central West Service Area Office