Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 14, 2016	2016_539120_0073	031295-16	Complaint

Licensee/Titulaire de permis

WATERDOWN LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

ALEXANDER PLACE
329 Parkside Drive P. O. Box 50 Waterdown ON L0R 2H0

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 Complaint inspection.

This inspection was conducted on the following date(s): November 28, 2016

Log #031295-16 - Complaint related to maintenance services, laundry services and resident health and safety.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Environmental Services Supervisor (ESS), registered staff, non registered staff, Activation Co-ordinator and Restorative Care Co-ordinator.

During the course of the inspection, the inspector toured the outdoor grounds of the home, toured two home areas on the ground floor (laundry room, resident rooms, linen storage rooms, tub/shower rooms), observed the condition of available linens, tested the self-closing devices on fire doors separating the home areas from the main corridor, reviewed laundry policies and procedures, reviewed resident clinical records and bed rail use assessments.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 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, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also

emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

For this inspection, resident #001 and resident #002 were selected for review as both had a bed rail attached to their beds which did not originally accompany the bed from the bed manufacturer. Both residents had the bed rail elevated and had either a progress note or a care plan indicating that they required the bed rail as a Personal Assistance Services Device (PASD).

Resident #001 was admitted to the home in late 2015 at which time a bed rail was not equipped on the bed frame. According to progress notes, a staff member became aware of the addition of a portable bed rail which was attached to the resident's bed frame three months later. The bed rail was subsequently removed until the resident could demonstrate that they could use it properly and for the physician to provide an order for it. Once the order was received, the bed rail was re-installed as a PASD, to allow for bed mobility and transferring. It was determined that a family member purchased the bed rail and brought it to the home. The resident was made aware of the fact that bed rails increased the risk of injury and could cause death. Verbal consent to continue to use the bed rail was given by the resident. The information regarding the bed rail was not included in the resident's written plan of care for direction to personal support workers (PSWs). When the resident was admitted to the home, they were diagnosed with a specific progressive age-related condition and a risk of falls, both factors to consider when determining if a bed rail is safe for resident use. .

During the inspection, the portable bed rail was observed to be tucked under the mattress with a large opening between two vertical bars on November 28, 2016. No horizontal rungs except for one at the top for gripping was included. The bed rail opening, according to Health Canada Guidelines titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, March 17, 2008" is known as zone 1. Zone 1 openings must not be greater than 12 centimeters dimensionally between the rungs or bars of the bed rail. In the case of the portable bed rail, the opening was greater than 20 centimeters. The size of the opening may contribute to various forms of entrapment and suspension of either the whole body or body parts. The Environmental Services Supervisor (ESS) who conducted bed entrapment audits in the home throughout the year reported that they were not aware of the portable bed rail for resident #001 and it was therefore not tested. The bed rail was removed post inspection and consideration was being made to attach a bed rail that was from the bed manufacturer that could pass all zones of entrapment.

Resident #002 was admitted to the home in mid 2016. One month later, the physician approved an order for one portable bed rail for repositioning and transfers. The resident's written plan of care identified that the resident used the bed rail for "transferring purposes". The bed rail that was observed on the bed on November 28, 2016 was fixed to the frame centrally but was not a bed rail that was supplied by the bed manufacturer or bed supplier. The resident verified that the bed rail was purchased by the family and brought into the home and installed. The ESS confirmed that the bed rail was tested and passed all zones of entrapment. The bed originally had a 3/4 sized bed rail on it when purchased by the home. However, the bed rails were removed when a previous resident had occupied it and did not require them. The DOC and Restorative Care Co-ordinator did not consider providing the resident with the manufacturers' bed rails which would have been the first step in ensuring the resident had the most appropriate bed rail for the bed. It is uncertain why the resident or their family would have needed to purchase a bed rail when one was already available or could have been provided within a few days. Arrangements were made with the resident post inspection to replace the bed rail with one from the manufacturer.

Both residents were assessed for use of their bed rails using the "Bed Mobility Assessment Tool". It was reviewed and noted to be missing several components listed in the Guidance document noted above. The licensee did not have any policies, procedures or forms to guide the evaluation process of the resident for bed rail safety.

A) The licensee's "Bed Mobility Assessment Tool" related to bed rails did not include a

component related to evaluating the resident's sleep patterns, habits and behaviours while sleeping in bed, first without the bed rails, followed by an observation with bed rails if required. Both residents when evaluated, were awake and were made to demonstrate to the evaluator whether their bed rail could be used for transfers or bed mobility. The evaluator did not conclude based on independent observation how the residents' sleep patterns and behaviours may have affected their safety while in bed and while the bed rail was in place.

B) The "Bed Mobility Assessment Tool" did not include a section where the assessor was to select what alternatives were trialled prior to applying the bed rails if they were indicated for a medical symptom or condition. The form did not include any options or a space to document what was trialled, if anything. For both resident #001 and #002, the forms did not include any information regarding what was trialled for each resident before implementing the hard bed rail that was observed on their beds.

C) The "Bed Mobility Assessment Tool" included some relevant questions to consider, but the answers to those questions were not documented on the form. The questions were presented as a list. These included medication use, falls history, bed entrapment and previous issues with bed systems, cognition, and ability to use the bed rail properly. However, other key questions that can be found in the Guidance document such as but not limited to toileting habits, environmental factors, body size, any involuntary or spasmodic body movements, medical conditions like Parkinson's, Dementia, or sleep disorders were not included. There was no further guidance on the form to direct the assessor in making any decisions as to whether the resident was at any risk of entrapment or injury if bed rails were to be applied. For resident #001, a specific medical condition was identified on the form, but no further information was documented as to whether the condition would have or could have any impact on the resident's safety while in bed with a bed rail in place.

D) The "Bed Mobility Assessment Tool" did not include the names of the interdisciplinary team members that participated in the assessment of the resident. For both residents #001 and #002, the only name listed on the form was that of the Restorative Care Co-ordinator. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the residents are assessed in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home was maintained in a good state of repair.

A paved walkway that was located mostly along the back side of the property of the long term care home and was provided for use by family and residents was observed to be in poor condition. An eight meter section of the walkway was covered in multiple holes approximately five to ten centimeters in diameter and had raised and rough edges. The rough surface would have presented a tripping hazard and difficulties for residents using a walker or wheelchair. According to the ESS, the walkway was inspected by a maintenance person monthly. The ESS was unaware of the condition of the walkway and therefore did not have any plans in place to repair it. [s. 15. (2) (c)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee did not ensure that procedures were implemented to ensure that a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents.

According to the licensee's procedure titled "Linen Inventory" dated April 2010, the ESS was required to "complete a monthly in-stock inventory, which included all linens kept in storage and linens used to replace discarded linen and maintain on-floor quotas". Once every three months or quarterly, the ESS was required to complete an "on-floor inventory in each home area" to ensure that adequate linen supplies continued to meet "resident needs on a regular daily basis".

According to the ESS, quarterly inventories were completed in the past and linens ordered to ensure that quotas listed in their procedures were met. Documents were provided for review confirming that a large order of linens was delivered to the home in October 2016. However, during the inspection, monthly inventories and on-floor quotas could not be established. Discussion with the full-time laundry person revealed that no daily quotas were posted in the laundry room for her to know how many bath, hand, peri care and face cloths to allocate to each home area. After processing various towels (all mixed in one machine), an unknown number of items were stuffed into a mesh bag for pick up by PSWs. Each home area was allocated 2 mesh bags containing peri care

cloths, hand, face and bath towels twice per day, once in the morning and once in the afternoon. After the morning delivery, the PSWs were required to return the soiled linen to laundry to be washed for the afternoon supply. If some of the morning linen supply was discarded or not returned to laundry, the afternoon supply would be short. No washed and ready to go linens were available in the laundry room. As the linens were not counted by laundry staff, PSWs would not receive adequate amounts of linens to distribute for resident use. The process of waiting to wash linens as they were received is an indication that an inadequate supply exists in the home.

Several mesh bags were checked during the inspection to determine typical content. When the contents were removed from one bag, there were 13 hand towels, 4 bath towels, 3 face cloths and 7 peri care cloths. Each bag contained a different amount of mixed linens. PSWs were interviewed about adequate supplies and they reported that shortages occurred in cycles in the past (between inventory and delivery of linens). PSWs reported that when they had inadequate amounts of a particular towel, they went to another home area to get them. A tour of the resident washrooms was conducted between 11 and 12 p.m. and again at 3:15 p.m. and revealed that most residents had some linens, whether a face cloth, bath towel, hand towel or peri care towel or a combination of all four. However, it could not be established for how long the linens were available to them and whether or not they had access to linens all day and not just at different times of the day.

Three residents were interviewed about their linen availability and two reported that they recalled shortages in the past with face cloths and hand towels and that they had to use paper towel to wipe their face and hands. One resident reported that it depended on who the PSW was.

The licensee did not ensure that procedures were implemented to ensure that a sufficient supply of clean linen, face cloths and bath towels were always available in the home for use by residents. [s. 89. (1) (b)]

2. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee did not ensure that procedures were implemented to ensure that linen, face cloths and bath towels are kept clean and sanitary and were maintained in a good state of repair and free from stains.

During a tour of two home areas on the ground floor, linens were observed in resident washrooms, linen storage rooms and on carts used by personal support workers (PSW).

Numerous hand towels, bath towels and face cloths were observed to be discoloured and appeared yellowed. Many of the face cloths and some of the hand towels had additional brown coloured blotches. On a linen cart with linens ready for distribution, one hand towel was badly ripped and another was threadbare and torn. No discard bin or receptacle was noted in either of the two linen storage rooms. The damaged linens were removed by the inspector and provided to the Administrator.

According to the licensee's "Disposal of Worn Linen" procedure dated April 2010, linens were to be inspected during the laundering process, when transferring linens between the dryer and the mesh bags. The procedure also identified that the responsibility of removing stained, frayed and discoloured linens was a responsibility of both the laundry and nursing departments. The procedure further identified that a discard bin or similar receptacle be located in each home area to store discarded items so they could be inventoried. The procedure did not identify how often the discarded items would be counted, however another policy titled "Linen inventory" identified that linen stock would be counted monthly to ensure adequate linen supplies were available, which would include ensuring that discarded items would be replaced.

According to the full time laundry aide, torn and stained linens could easily be missed during the drying stage as towels were not required to be folded or laid out flat before being distributed. The linens were stuffed into mesh bags and picked up by PSWs who were required to pull them out of the bags, fold them and distribute them to residents. The task of pulling stained and damaged linens out of circulation was therefore a task for all staff, not just laundry staff. If PSWs observed damaged or stained linens, they were required to inform the ESS. Interviews with PSWs revealed that face cloths and hand towels were occasionally in short supply throughout the year and damaged and stained linens were therefore not removed from circulation in order to have an adequate supply.

According to the ESS, who was aware of the yellowed linen, a full inventory (completed quarterly) was due within the home on November 30, 2016 and a linen service provider was due to visit the home on December 1, 2016 to determine why the linen was yellowing. On December 2, 2016, the ESS reported that a hose was cracked preventing the de-staining agent from being adequately dispensed into one of the washing machines used to wash bath towels, face cloths and hand towels. The hose was replaced on December 2, 2016 and linens re-washed.

The licensee did not ensure that all staff followed the licensee's procedures for ensuring that torn and stained linens were removed from circulation, that the discarded items were

counted and arrangements made to replace the linens as needed. [s. 89. (1) (c)]

Issued on this 14th day of December, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.