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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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119 King Street West 11th Floor
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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
Jul 20, 2015	2015_189120_0056	H-002568-15	Follow up

Licensee/Titulaire de permis

BLACKADAR CONTINUING CARE CENTRE INC.
101 CREIGHTON ROAD DUNDAS ON L9H 3B7

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

BLACKADAR CONTINUING CARE CENTRE
101 CREIGHTON ROAD DUNDAS ON L9H 3B7

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

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

This inspection was conducted on the following date(s): July 13, 2015

An inspection (2015-337581-0003) was previously conducted on January 29 to February 12, 2015 at which time Order #001 was issued related to bed safety. For this follow-up visit, the conditions laid out in the Order were not fully met and the Order is being revised. See below for details.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered staff and Personal Support Workers. The Inspector observed residents in bed, reviewed resident health care records, bed system audit reports, resident bed rail device assessment survey and observed the method used to test a resident bed system.

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)**
- **2 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.

An inspection was previously conducted on February 10, 2015 and non-compliance identified with respect to the completion of a clinical safety assessment of all residents using one or more bed rails. Prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, April 2003" developed by the US Food and Drug Administration and adopted by Health Canada specifies that resident's who require a bed rail for an assessed reason, are evaluated by an interdisciplinary team (i.e Physiotherapist, Personal Support Worker, Registered Nurse) to determine if a bed rail poses a risk for injury based on their toileting habits, environment, sleeping patterns, habits, behaviours, cognition, mobility, communication, medical diagnosis, medication use etc. According to the Director of Care, no formal questionnaire was developed or used, residents were not monitored or evaluated over a period of time for sleeping habits and rail use patterns or had trialled any interventions before a rail was considered the appropriate medical device for them. Information regarding resident rail use was completed by the Director of Care and and a Quality Care Nurse by informally gathering information from the resident and staff members whether or not a resident was using a rail and the reason. The information was subsequently transferred to the resident's plan of care. During the inspection, the plan of care for 6 residents was reviewed and confirmation made that each had bed rail information in the plan. However, no formal assessment could be located for any of the residents as to how and why the decision was made and whether an alternative was trialled and the outcomes of those

alternatives. [s.15(1)(a)]

2. The licensee did not ensure that where bed rails were used, the resident's bed system was evaluated in accordance with prevailing practices.

The licensee arranged to have all of the bed systems evaluated for entrapment zones in the home in January 2015 by an external contractor. During a tour of the home's bed systems, one bed in particular was observed to have a large gap between a bed rail and the mattress. The maintenance person who was trained by the external contractor to test the beds was asked to have the bed re-tested. While the test was being conducted, it was determined that a pressure gauge that was to be used with the measurement tool was not functioning. The maintenance person who was allocated the duty to measure the beds confirmed that the gauge was not used in January 2015 or at any other time the beds were re-tested after January 2015. The beds were therefore not measured for entrapment in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006". The guidelines identified how the tool was to be used and that for certain zones, a pressure gauge was to be used. The results that were presented at the time of the inspection could therefore not be used to confirm the status of the bed systems in the home. [s. 15(1)(a)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 20th day of July, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2015_189120_0056
Log No. / Registre no:	H-002568-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 20, 2015
Licensee / Titulaire de permis :	BLACKADAR CONTINUING CARE CENTRE INC. 101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7
LTC Home / Foyer de SLD :	BLACKADAR CONTINUING CARE CENTRE 101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jarrod McIntosh

To BLACKADAR CONTINUING CARE CENTRE 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: 2015_337581_0003, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following;

1. Develop or incorporate a comprehensive bed safety clinical assessment tool (form, questionnaire) using the US Federal Drug and Food Administration document as a guide titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
2. An interdisciplinary team shall assess all residents using the bed safety clinical assessment tool and document the results and recommendations.
3. Update all resident health care records to include why bed rails are being used, how many, the size and any accessories that are required to mitigate any identified entrapment risks.
4. Health care staff providing care to residents shall be provided with and follow directions related to each resident's bed rail use requirements.
5. All health care staff who provide direct care to residents shall receive education with respect to bed safety, entrapment risks and appropriate bed rail use.

Grounds / Motifs :

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.

An inspection was previously conducted on February 10, 2015 and non-compliance identified with respect to the completion of a clinical safety assessment of all residents using one or more bed rails. Prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, April 2003" developed by the US Food and Drug Administration and adopted by Health Canada specifies that resident's who require a bed rail for an assessed reason, are evaluated by an interdisciplinary team (i.e Physiotherapist, Personal Support Worker, Registered Nurse) to determine if a bed rail poses a risk for injury based on their toileting habits, environment, sleeping patterns, habits, behaviours, cognition, mobility, communication, medical diagnosis, medication use etc. According to the Director of Care, no formal questionnaire was developed or used, residents were not monitored or evaluated over a period of time for sleeping habits and rail use patterns or had trialled any interventions before a rail was considered the appropriate medical device for them. Information regarding resident rail use was completed by the Director of Care and and a Quality Care Nurse by informally gathering information from the resident and staff members whether or not a resident was using a rail and the reason. The information was subsequently transferred to the resident's plan of care. During the inspection, the plan of care for 6 residents was reviewed and confirmation made that each had bed rail information in the plan. However, no formal assessment could be located for any of the residents as to how and why the decision was made and whether an alternative was trialled and the outcomes of those alternatives.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1. Re-assess all bed systems in accordance with the Health Canada Guidelines tilted "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006".
2. Document the findings of the assessment and any follow-up actions taken.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, the resident's bed system was evaluated in accordance with prevailing practices.

The licensee arranged to have all of the bed systems evaluated for entrapment zones in the home in January 2015 by an external contractor. During a tour of the home's bed systems, one bed in particular was observed to have a large gap between a bed rail and the mattress. The maintenance person who was trained by the external contractor to test the beds was asked to have the bed re-tested. While the test was being conducted, it was determined that a pressure gauge that was to be used with the measurement tool was not functioning. The maintenance person who was allocated the duty to measure the beds confirmed that the gauge was not used in January 2015 or at any other time the beds were re-tested after January 2015. The beds were therefore not measured for entrapment in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Entrapment Hazards, Latch reliability and other hazards." The guidelines identified how the tool was to be used and that for certain zones, a pressure gauge was to be used. The results that were presented at the time of the inspection could therefore not be used to confirm the status of the bed systems in the home. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 20th day of July, 2015

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