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
May 4, 2015	2015_189120_0027	H-001968-15	Follow up

Licensee/Titulaire de permis

THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA
155 PANIN ROAD BURLINGTON ON L7P 5A6

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

CAMA WOODLANDS NURSING HOME
159 PANIN ROAD BURLINGTON ON L7P 5A6

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): April 21, 2015

A follow-up inspection (2015-189120-0001) was previously conducted on December 30, 2014 to determine compliance with Order #001 that was issued regarding bed safety and resident assessments for bed rail use. For this follow-up inspection, the conditions that were laid out in the Order were not met and a revised Order is being issued.

During the course of the inspection, the inspector(s) spoke with the Administrator, Chief of Nursing and Director of Care. Resident health care records and a bed safety entrapment audit were reviewed and random residents were observed using their beds.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the residents were assessed in accordance with prevailing practices to minimize risk to the resident where bed rails were used. Prevailing practices includes a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Food and Drug Administration.

The licensee was identified to be non-compliant during two previous inspections, initially on June 12, 2014 when residents were located at St. Olga's Lifecare Centre and secondly, on December 30, 2014, after residents moved to their current location identified as Cama Woodlands. Both Orders issued required the licensee to develop a comprehensive bed safety assessment tool using the above noted document, assess all residents using the bed safety assessment tool, update the residents' plan of care to include bed rail use and to educate all health care staff with respect to bed rail use and bed safety entrapment zones. The conditions were not met during this follow-up inspection and are being re-issued based on the findings below;

During the inspection on April 21, 2015, four identified residents were observed to be sleeping in a bed with one or more bed rails elevated. Three out of the four did not have any information in their health care records that any rails were to be applied while in bed. One resident record identified that quarter bed rails were to be applied when in bed but did not provide any reasons.

Completed bed safety assessment forms or documentation could not be provided during

the inspection by the management staff as to how and by whom the residents were assessed to determine if bed rails were in fact necessary, whether they were safe for the particular resident, whether alternatives were trialed and whether interventions were needed to mitigate any identified risks. [s. 15(1)(a)]

2. The licensee did not ensure that where bed rails were used that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) An identified resident was observed to be sleeping on therapeutic air mattress during the inspection and did not have any bolsters or gap fillers between the air mattress and their rotating assist bed rails which were both elevated. A large gap was visually observed between the resident's air mattress and the rail. The resident's health care record did not identify that the resident required the application of any bed rails. No bolsters, bed rail pads or other accessory was applied to the bed to mitigate any entrapment risks. The air mattress was very soft and flexible and inherently had entrapment risks due to it's design.

B) Residents in three identified rooms were equipped with a therapeutic air mattress but were not in bed at the time of observation. The bed in one room had four quarter rails elevated but their health care record identified that two were to be applied but did not provide a reason. The other two identified residents did not have any information in their health care record that one or more rails were required when in bed. A personal support worker confirmed that she applied both rails (and in some cases all four quarter rails) for each of the identified residents after assisting them to bed during her shift. The identified residents did not have any bolsters, bed rail pads or other accessories in their room or on their beds to mitigate or eliminate entrapment risks while in bed. The air mattresses were very soft and flexible and inherently had entrapment risks due to their design.

In discussion with the Director of Care, the application of entrapment mitigating accessories for all residents on mattresses that were flexible and soft had not been considered to mitigate any potential entrapment risks. [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 4th day of May, 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_0027
Log No. / Registre no:	H-001968-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 4, 2015
Licensee / Titulaire de permis :	THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA 155 PANIN ROAD, BURLINGTON, ON, L7P-5A6
LTC Home / Foyer de SLD :	CAMA WOODLANDS NURSING HOME 159 PANIN ROAD, BURLINGTON, ON, L7P-5A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ARLENE LAWLOR

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

To THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA, 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_189120_0001, 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 a comprehensive bed safety assessment tool using as a guide the US Federal Food and Drug Administration document 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 assessment of all residents using the bed safety assessment tool shall be completed and the results and recommendations of the assessment shall be documented.
3. Update all resident health care records to include why bed rails are being used, how many are to be used and any accessories that are required to mitigate any identified entrapment or safety risks.
4. Educate all health care staff with respect to when to apply bed rails for each resident, why they are being applied and general bed safety hazards.

Grounds / Motifs :

1. The licensee did not ensure that the residents were assessed in accordance with prevailing practices to minimize risk to the resident where bed rails were used. Prevailing practices includes a document endorsed by Health Canada

titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Food and Drug Administration.

The licensee was identified to be non-compliant during two previous inspections, initially on June 12, 2014 when residents were located at St. Olga's Lifecare Centre and secondly, on December 30, 2014, after residents moved to their current location identified as Cama Woodlands. Both Orders issued required the licensee to develop a comprehensive bed safety assessment tool using the above noted document, assess all residents using the bed safety assessment tool, update the residents' plan of care to include bed rail use and to educate all health care staff with respect to bed rail use and bed safety entrapment zones. The conditions were not met during this follow-up inspection and are being re-issued based on the findings below;

During the inspection on April 21, 2015, four identified residents were observed to be sleeping in a bed with one or more bed rails elevated. Three out of the four did not have any information in their health care records that any rails were to be applied while in bed. One resident record identified that quarter bed rails were to be applied when in bed but did not provide any reasons.

Completed bed safety assessment forms or documentation could not be provided during the inspection by the management staff as to how and by whom the residents were assessed to determine if bed rails were in fact necessary, whether they were safe for the particular resident, whether alternatives were trialed and whether interventions were needed to mitigate any identified risks. (120)

2. The licensee did not ensure that where bed rails were used that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) A identified resident was observed to be sleeping on therapeutic air mattress during the inspection and did not have any bolsters or gap fillers between the air mattress and their rotating assist bed rails which were both elevated. A large gap was visually observed between the resident's air mattress and the rail. The resident's health care record did not identify that the resident required the application of any bed rails. No bolsters, bed rail pads or other accessory was applied to the bed to mitigate any entrapment risks. The air mattress was very

soft and flexible and inherently had entrapment risks due to it's design.

B) Residents in 3 identified rooms were equipped with a therapeutic air mattress but were not in bed at the time of observation. The bed in one room had four quarter rails elevated but their health care record identified that two were to be applied but did not provide a reason. The other two identified residents did not have any information in their health care record that one or more rails were required when in bed. A personal support worker confirmed that she applied both rails (and in some cases all four quarter rails) for each of the identified residents after assisting them to bed during her shift. The identified residents did not have any bolsters, bed rail pads or other accessories in their room or on their beds to mitigate or eliminate entrapment risks while in bed. The air mattresses were very soft and flexible and inherently had entrapment risks due to their design.

In discussion with the Director of Care, the application of entrapment mitigating accessories for all residents on mattresses that were flexible and soft had not been considered to mitigate any potential entrapment risks. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 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 4th day of May, 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