Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'Inspection
January 10 &11, Feb. 10, 2011	2011-171-2721-10Jan115124 2011-120-2721-10Jan170631 2011-127-2721-10Jan111830 2011-169-2721-16Feb112514	H-02840 - Complaint

Licensee/Titulaire

Clarion Nursing Homes Limited, 337 Highway #8, Stoney Creek, ON, L8G 1E7

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

Clarion Nursing Home, 337 Highway #8, Stoney Creek, ON, L8G 1E7

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

Elisa Wilson #171 – Dietary, Bernadette Susnik #120 – Environmental, Richard Hayden #127-Environmental, Yvonne Walton, Nursing #169

Inspection Summary/Sommaire d'inspection

The purpose of this visit was to conduct a complaint inspection related to various resident care issues which encompass the dietary, nursing and environmental departments.

During the course of the inspection, the inspectors spoke with the Administrator, Director of Care, Environmental Services Supervisor, maintenance person, registered staff, personal support workers, foodservices manager, dietitian, cook, activities coordinator and residents.

During the course of the inspection, the inspectors inspected the beds (photographs taken), conducted a clinical review relating to falls management, reviewed records/reports kept by maintenance personnel, maintenance policies and procedures, plans of care and daily flow sheets for three residents and the menu cycle, and requested and received copies of the bowel management, daily flow sheets and bed rail use policies.

The following Inspection Protocols were used during this inspection:

Food Quality, Continence Care and Bowel Management, Minimizing of Restraining, Personal Support Services, Safe and Secure Home and Accommodation Services – Maintenance, Prevention of Abuse, Neglect and retaliation

Findings of Non-Compliance were found during this inspection. The following action was taken:

10 WN
6 VPC
3 CO - #001, #002, #003

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: ***The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6(7).*** The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:

The plan of care for an identified resident indicates that the bed rails should be up at all times to prevent self-transferring and the possibility of a fall. On January 10, 2010 one bed rail was down when the resident was in bed resting and when out of bed.

Inspector ID #:	171

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: ***The licensee has failed to comply with O.Reg. 79/10, s. 17(1)(a).*** Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

Findings:

The call bell for an identified resident was found entangled in other cords and noted to be lying at the side of the bed, out of their reach, on January 10, 2011. The resident was in bed at the time and was calling out for assistance.

Inspector ID #:	171

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 the resident's call bell can be easily seen, accessed and used by residents, to be implemented voluntarily.

WN #3: ***The licensee has failed to comply with O. Reg. 79/10, s. 30(2).*** The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Findings:

The responses to bowel interventions are not always documented for the identified resident. The resident was given a suppository, after three days with no bowel movement documented. There is no indication on the medication sheet, daily communication book or the daily flow sheets regarding the effectiveness of this treatment. The resident received another suppository five days later with no documented bowel movements between these two dates, however there are three days with no information documented regarding bowel movements, therefore it is unclear if the bowel protocol was being followed.

Inspector ID #:	171

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 interventions and resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: ***The licensee has failed to comply with O. Reg. 79/10, s. 8(1)(b).*** Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, and
(b) is complied with.

Findings:

The Home has a policy titled "Daily Flow Sheets" which describes the roles and responsibilities of staff on each shift to complete the flow sheets regarding the particulars of resident care during their shift. Some of the areas were not completed as per policy for identified residents.

- An identified resident had missing information for the day shift regarding bowel movements on five days in December 2010 and five days in November 2010. Due to the fact this information is unknown, the potential is that the resident had five 3-day stretches without a bowel movement. This would be important information for the team when reassessing his plan of care and potential need for bowel interventions.
- The resident had missing information regarding bowel movements for four day shifts and three evening shifts in December 2010 and six day shifts in November 2010. In November, the documentation does not indicate a bowel movement for nine days, however four of those days have missing information. This information is important for the team when reassessing bowel interventions.

Inspector ID #:	171

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 the Home's policies are complied with, to be implemented voluntarily.

WN #5: ***The licensee has failed to comply with O. Reg. 79/10, s. 9.1.iii.*** Every licensee of a long-term care home shall ensure that the following rules are complied with:

1.All doors leading to stairways and the outside of the home must be,

iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Findings:

Various stairwell doors, which are equipped with magnetic locking systems were tested to determine if an audible alarm would sound when the doors did not close properly after opening. Doors labeled as zone 1, 5 & 6, did not sound at the door or anywhere else in the home. The visual signal on the panels at the nurse's stations did not light up. Manual reset switches located at each door for zones 5 & 6 were on by-pass. Keys to re-engage the alarms were requested of the staff on the lower floor. Staff indicated that they were not aware of the purpose of the reset switch at the door and had never used it before and therefore did not know about any keys.

The door on the main floor (zone 1), near the offices, was tested while it was off by-pass. Keys for the reset switch were not available to the charge nurse on this floor upon request, but found a short time thereafter by the Director of Care.

Inspector ID#	120

Additional Required Actions:

CO – #001 Refer to the "Order of the Inspector" form for further details.

WN#6: ***The licensee has failed to comply with the LTCHA, 2007, S.O., 2007, c.8, s. 5.*** Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Findings:

The stairwell located on the ground floor, which leads to the lower level, is fully accessible to 50 residents residing on the main floor, 29 of which use wheelchairs and 20 of which use either a walker or cane. A pole exists at the top of the landing, to prevent residents in wheelchairs from rolling down the stairs, however no other barrier, mechanism or system exists to prevent entry to the stairwell.

Inspector ID#	120 & 127

Additional Required Actions:

CO - #002 Refer to the "Order of the Inspector" form for further details.

WN#7: ***The licensee has failed to comply with O. Reg., 79/10, s. 91.*** Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times.

Findings:

- Both 1st floor soiled utility rooms and a soiled utility room on the 2nd floor were left unlocked on January 11, 2011. One of these rooms was left unlocked on both days of the inspection. One room contained

bleach (hazardous substance) in a spray bottle and another contained a spray bottle of Accel TB containing accelerated hydrogen peroxide (disinfectant – hazardous substance). The soiled utility room on the 2nd floor had a large jug of sodium hypochlorite (bleach) accessible under the sink. All of the soiled utility rooms have keys attached to the door above the locks which can easily be used by residents to gain access to the rooms.

- A housekeeping cart was left unattended on the 1st floor (dementia unit) on January 11th, 2011 for 12 minutes. The cart was not locked and a cleaner containing phosphoric acid (hazardous substance) was accessible to residents.

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 hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.

Inspector ID#	120 & 127

WN#8: ***The licensee has failed to comply with O. Reg. 79/10, s. 15(1)(a) & (c).*** 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.

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Findings:

- Accessory bed devices, given the term "bed rail bars" by the home and identified in their bed rail use policy, were observed to be in use in several resident rooms, while residents were either sleeping or awake. The bed rail bars span out over top of the resident and sit on top of both bed rails. These bed rail bars appeared to be custom manufactured, with no manufacturer's markings and not supplied by a bed accessory manufacturer. The purpose of the bed rail bars, as described in the home's policy, is to keep residents from lifting the bed rails out of place. The bed rail bars have not been assessed for resident safety and are not approved for use to prevent a resident from unlatching a bed rail. Numerous beds in the home (over 70%) have bed rails that do not latch and therefore do not conform to the side rail latching guidelines under Health Canada's Guidance Document entitled *"Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and other Hazards".* According to this guideline, bedrails must latch so that a resident cannot disengage a bed rail in any direction. In this home, the bedrails do not latch to prevent a resident from lifting them up and out of place, and the home has therefore instituted the use of the bed rail bars.
- An identified resident injured themselves when they climbed up and over the bed rails and then fell to the floor. The bed was not an adjustable bed and could not be lowered closer to the floor.

Inspector ID#:	120 & 127

Additional Required Actions:

CO - #003 Refer to the "Order of the Inspector" form for further details.

WN #9: The licensee has failed to comply with *LTCHA, 2007, S.O., 2007, c.8, s. 6 (4)(a).* Every licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and

complement each other

Findings:

- An identified resident had two falls in July, 2010. The resident was found on both occasions beside their bed on the floor in a sitting position. The incident report identified that the resident was attempting to self transfer into the bed and fell. The response of the home was to put both bedrails up to prevent the resident from self transferring into bed. The second incident occurred while the resident was attempting to self transfer into bed again, but was unable to do so due to the bedrail being up. The response of the home was to keep both bedrails up while the resident was in bed or out of bed, to prevent self transferring into their chair.
- Assessments were completed by the physician, physiotherapist and nursing in 2010 for the identified resident. ~~The physician's assessment includes only ordering x-rays, the physiotherapists and nursing assessment only states the resident is high risk for falls~~. The inter-disciplinary team are aware of the falls, however the assessments are not integrated and there is no evidence the team has collaborated.

Inspector ID #:	169

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 staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with *LTCHA, 2007, S.O., 2007, c.8, s. 6 (1)(c).* Every licensee of a long term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) Clear directions to staff and others who provide direct care to the resident.

Findings:

- An identified resident had two falls in July 2010. The post fall assessment provided direction regarding the use of bedrails. The plan of care does not reflect the interventions determined, regarding the use of bedrails.

Inspector ID #:	169

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** B. Dumik for C. Wilson.
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Bernadette Susnik	**Inspector ID #**	120
Log #:	H-02840		
Inspection Report #:	2011-120-2721-10Jan170631		
Type of Inspection:	Complaint		
Date of Inspection:	January 10, 11, 2011		
Licensee:	Clarion Nursing Homes Limited, 337 Highway #8, Stoney Creek, ON, L8G 1E7		
LTC Home:	Clarion Nursing Home, 337 Highway #8, Stoney Creek, ON, L8G 1E7		
Name of Administrator:	Michael Jancic		

To ***Clarion Nursing Homes Limited***, you are hereby required to comply with the following order by the dates set out below:

Order #	001	**Order Type**	Compliance Order, Section 153 (1)(a)

Pursuant to: Ontario Regulation 79/10, s. 9.1.iii. A. & B. Every licensee of a long-term care home shall ensure that the following rules are complied with:

1.All doors leading to stairways and the outside of the home must be,

iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Order:

The licensee shall complete the following;

1. All doors leading to stairwells and to the outside of the home from the lower and upper floor of the home are to be connected to the audio visual enunciator. The lower floor doors are to be connected to the enunciator panel located at the lower floor nurse's station and the main floor doors are to be connected to the enunciator panel located at the main floor nurse's station.

2. All charge nurses and management staff are to be trained with respect to how the door reset switches operate and have convenient access to the key that is used to reset the switches at each door.

Grounds:

Various stairwell doors were not connected to the audio visual enunciator panel, which are located at each of the two nurse's stations. Doors labelled zone 1, 5 & 6, which are equipped with a magnetic locking system, were tested by the Inspector to determine if an audible alarm would sound when the doors did not close properly after opening. Doors labelled zone 1, 5 & 6, did not sound at the door or at the enunciator panel located at the nurse's station closest to that door. Manual reset switches located at each door for zones 1, 5 & 6 were on by-pass. Keys to re-engage the alarms were requested of the staff on both floors. Some staff indicated that they were not aware of the purpose of the reset switch at the door and had never used it before and therefore did not know about the keys.

Keys for the reset switches were eventually found by the Director of Care. The door on the main floor (zone 1), near the offices, was tested again, while it was off by-pass, however it did not sound at the enunciator panel or at the door and was therefore not connected.

The Order must be complied with by:	May 15, 2011

Order #	002	**Order Type:**	Compliance Order, Section 153(1)(b)

Pursuant to: The LTCHA, 2007, S.O., 2007, c..8, s.5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Order:

The licensee shall:

1. Prepare and submit a plan to the Inspector by April 28, 2011 which identifies and addresses the safety risks posed by the open stairwell on the ground floor and include in the plan proposed timelines by which the identified risks will be addressed: and
   - identified risks are prioritized so that residents at highest risk are to be addressed as first priority; and
   - all areas of risk shall be addressed within 6 months of the date of this Order; and

2. Implement the plan in accordance with the timelines approved by the Inspector.

The written plan shall be submitted to Bernadette Susnik, Long-Term Care Homes Inspector, Ministry of Health and Long -Term Care, Performance Improvement and Compliance Branch, 119 King St. W., 11th floor, Hamilton, ON, L8P 4Y7.

Grounds:

The stairwell located on the ground floor, which leads to the lower level, is fully accessible to 50 residents residing on the main floor, 29 of which use wheelchairs and 20 of which use either a walker or cane. A pole exists at the top of the landing, to prevent residents in wheelchairs from rolling down the stairs, however no other barrier, mechanism or system exists to prevent entry to the stairwell and mitigate risk to the residents.

The Order must be complied with by:	October 15, 2011

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: Ontario Regulation 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.
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Order:

The licensee shall:

a) ensure that all appropriate steps are immediately taken to mitigate any risks to residents where "bed rail bars" are in use.
b) ensure that an evaluation is immediately conducted of all resident bed systems which includes latch reliability in accordance with Health Canada's Guidance Document entitled *"Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and other Hazards"* and
c) prepare and submit a plan to the Inspector by May 15, 2011 to address all areas identified by the evaluation required under a) above that present risks to residents and include in the plan proposed timelines by which the areas that present risks to residents are addressed:
    a. that are prioritized on the level of risk where those areas that pose the highest risk to residents are to be addressed as a first priority; and
    b. all areas shall be addressed within two months of the date of this Order.
d) implement this plan in accordance with the timelines approved by the Inspector.

The written plan shall be submitted to Bernadette Susnik, Long-Term Care Homes Inspector, Ministry of Health and Long -Term Care, Performance Improvement and Compliance Branch, 119 King St. W., 11th floor, Hamilton, ON, L8P 4Y7.

Grounds:

- Accessory bed devices, given the term "bed rail bars" by the home and identified in their bed rail use policy, were observed to be in use in several resident rooms, while residents were either sleeping or awake. The bed rail bars span out over top of the resident and sit on top of both bed rails. These bed rail bars appeared to be custom manufactured, with no manufacturer's markings and not supplied by a

bed accessory manufacturer. The purpose of the bed rail bars, as described in the home's policy, is to keep residents from lifting the bed rails out of place. The bed rail bars have not been assessed for resident safety and are not approved for use to prevent a resident from unlatching a bed rail. Numerous beds in the home (over 70%) have bed rails that do not latch and therefore do not conform to the side rail latching guidelines under Health Canada's Guidance Document entitled *"Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and other Hazards"*. According to this guideline, bedrails must latch so that a resident cannot disengage a bed rail in any direction. In this home, the bedrails do not latch to prevent a resident from lifting them up and out of place, and the home has therefore instituted the use of the bed rail bars.	
The Order must be complied with by:	May 15, 2011

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 15th day of April, 2011.	
Signature of Inspector:	B. Susnik
Name of Inspector:	Bernadette Susnik
Service Area Office:	Hamilton