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 prévue le Loi de 2007 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 Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 03, 2017;	2016_287548_0029 (A1)	032133-16	Critical Incident System

Licensee/Titulaire de permis

DUNDAS MANOR LIMITED
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

DUNDAS MANOR NURSING HOME
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

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 prévue le Loi de 2007 les foyers de soins de longue durée

RUZICA SUBOTIC-HOWELL (548) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

As per Licensee request on December 23, 2016, new compliance dates are being issued for CO #002 and CO #003.

Issued on this 3 day of January 2017 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

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

RUZICA SUBOTIC-HOWELL (548) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 9, 10, 15, 18, 2016 (onsite) November 23 and 24, 2016 (offsite)

During the course of the inspection: the inspector observed resident rooms, reviewed resident health care records, home investigative notes, policies and maintenance records.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), RAI Coordinator, Family member, Registered nurses (RN), Registered practical nurses (RPN), Personal support workers (PSWs), Maintenance Supervisor and Maintenance workers.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition

Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
0 VPC(s)
3 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 LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. A critical incident report was submitted to the MOHLTC on an identified day in 2016. Resident #010 was found wrapped in a top sheet with an appendage to be resting on the base board heater (BBH).

The initial assessment described an injury to the appendage.The injury was treated by RPN #101 who discovered the resident #010 and indicated that she was not certain what had caused the injury.

At approximately 0700 hours RN #111 and RPN #107 assessed the appendage and notified the physician and Substitute decision-maker (SDM).

Resident #010 was transferred to hospital with an altered skin integrity of unknown origin. Upon assessment it was determined that the resident be transported to another hospital for specialized care related to the injury.

The health care record and the home's investigative notes were reviewed related to the critical incident report.

The Resident #010 requires extensive assistance for all activities of daily living. The day prior to the incident the post bath assessment indicated that there were no identified alterations in the resident's skin integrity to the affected area. This was later confirmed during an interview on November 9, 2016 with PSW #102 who gave the resident's bath.

On November 9, 2016 during an interview RPN# 101 indicated to inspector #548 that when she entered the room she found the resident's upper torso to be partially on the bed on the mattress pad alarm and the resident's appendage to be resting on the (BBH). She removed the resident from the (BBH) and treated the area. In discussion, RPN #101 indicated that she found the room to be "overly hot" and noted that the thermostat dial was past the number 25. The thermostat is affixed on the wall adjacent to resident bed and the unit is composed of a dial affixed to a box anchored to the wall. There are numbers on the unit. She readjusted the thermostat lowering the temperature and the resident was monitored by staff for the remainder of the shift.

On November 9, 2016 during an interview with inspector #548, PSW #102

indicated that at the time of the incident the resident's #010 bed was close to the (BBH). Staff were unable to walk alongside the bed on the side of the BBH to provide care having to shuffle their feet one in front of another.

On the same day, November 9, 2016, RPN #101 concurred that it was difficult to move along the (left) side the bed due its proximity to the (BBH) and window. Additional interviews conducted with: ADOC #103, maintenance supervisor #100, PSW #102, SDM, RN #111 and PSW #115; they all indicated that the bed was close to the (BBH) "for a period of time" or "since the resident's admission to the room". The resident was admitted to an identified room on a specified date in 2016. From the DOC's investigative notes dated November 8, 2016 PSW #106 indicated that the bed was in the same position, close to the window, since the resident's admission to the room.

In the resident's room, tthe thermostat is affixed on the wall adjacent to resident bed. The thermostat unit is composed of a dial affixed to a box anchored to the wall. The dial has inscribed lines, numbers and dots around a dial. The dial was easily manipulated by the inspector #548 from number 0 to 25. The word Celsius is at the six o'clock location on the unit. The maintenance supervisor #100 confirmed that when the dial is placed at the three o'clock position the thermostat reading is at 30 degrees Celsius. Inspector #548 accessed and easily adjusted the temperature dial on the thermostat. On November 10, 2016 during an interview with the inspector #548 the maintenance supervisor #100 indicated he makes weekly rounds of each resident`s room to adjust the thermostat and noted that the resident's bed was parallel to and in "close" proximity to the (BBH). Maintenance supervisor #100 provided to the inspector #548 record of the weekly rounds completed a few days before the incident. For resident's #010 room he indicated that the bed side table was on the right hand side of the bed and the bed was "close" to the (BBH). The (BBH) is located on the left side of the resident's bed. Residents are provided a bed, bed side table and chair. Discretion is given to residents and/families to configure these items in resident rooms. Of the staff interviewed, above, they acknowledged that there are several other residents whose beds were "close" to the (BBH). On November 9, 2016 it was observed by inspector #548 additional rooms on the unit that each resident bed is parallel to the (BBH). Post incident the maintenance supervisor indicated that he measured the distance of the bed from the heater, length of (BBH) and thermostat accessibility in each resident room. Record of this measurement on the unit indicated that those beds were 10 inches away from the (BBH). He indicated that he could not measure the resident's room as the bed had been moved away from the (BBH), post

incident.

The resident was admitted and interviewed staff were aware of the bed placement in relation to the room's baseboard heater since the resident's admission to the room. There was no assessment conducted to determine optimal environmental safety for resident #010. [s. 5.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidenced-based practise and, if there are none, in accordance with prevailing practises, to minimize risk to the resident.

Related to the critical incident report above.

The resident #010 was admitted to the home on an identified date into a specified room, then moved on two separate occasions to other resident rooms. The last transfer was done on a specified date to the resident's current identified bed - bed room.

The home provided documentation titled: Entrapment Inspection dated January 2016 on beds-in-use at the home. The bed number and make, mattress type and number, if the mattress has a perimeter edge, location of bed frame and mattress by room and bed number and, individual columns titled Zones 1 through 7.

The home has several different types of mattresses: Zenith Regular, Zenith TriGel, Span Geo, MC Health, Zephair, Other Air and STG-IV. The home's bed frame types are MC and Invacare. The MC bed frame comes with either wheels tucked up or with wheels down as confirmed by maintenance worker #104.

It is recorded in the above document that the resident's bed number is 62, bed model is MC with a ZR mattress-with perimeter edge. The mattress number is recorded as M79. There are check marks in each column for zones 1to 7.

On November 18, 2016 at approximately 10:30 inspector #548 and #133 entered the resident's room.

Maintenance workers #104 and #112 explained they were installing a full rail on the right side of the resident's bed; as per family request. Maintenance worker #104 indicated that the mattress followed the resident from her initial admission to each room location. Maintenance supervisor #100 indicated that each bed system is measured on an annual basis and the results recorded in the Entrapment Inspection document. He indicated that the zones were checked by the home and the checkmarks in the columns titled zones 1 through 7 indicated that the bed system passed the evaluation. The maintenance supervisor confirmed resident's #010 mattress was moved from one room to the present room existing bed frame, with no evaluation of the resulting bed system.

The Health Canada guidance document, Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, Effective Date: 2008/03/17 (HC guidance document) goal is to reduce potential life-threatening

entrapments associated with bed systems involving an interdisciplinary approach that includes the bed design, clinical assessment and monitoring and, meeting family and resident needs. All long-term care homes were directed to use this as a best practice document in 2012 by the Director under the LTCHA 2007.

Bed rails are an integral component to the bed system and the HC guidance document speaks to the need to assess residents for risk related to bed rail use. As endorsed by the guidance document the current prevailing practices; "Clinical Guidance For The Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003" provides guidance for the assessment of the resident where bed rails are used.

The clinical guidance document describes that the individual resident assessment be a documentation of the risk-benefit assessment and be available within the health care record. The clinical guidance document describes the assessment to include individual resident assessment, sleeping environment assessment and treatment programs/care plans.

In discussion with inspector's #548 and #133 on November 18, 2016 with the DOC she indicated that the beds at the home are equipped with ¼ bed side rails at the head of the bed. She further reported that all residents are not assessed for the need and use of bed rails and the use of bed rails is not care planned. Bed rails are used automatically by staff in the home. The home conducts standardized bed assessments however, resident's #010 bed was not assessed specific to the resident's needs. [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or the care set out in the plan is no longer necessary.

Related to the critical incident report above.

The resident #010 is dependent on staff for activities of daily living and is identified as a high risk for falls.

The resident was found on the floor at the bedside on the three separate occasions in 2016. Review of the three post-fall assessments indicated that the resident #010 attempted to crawl or get out of bed. Fall interventions specified in the October 2016 care plan calls for the use of a mattress pad alarm and the resident was placed on the home's falling leaf program. The resident uses a mechanical lift, two person assistance for transfers and mobilizes with use of a wheelchair.

The health record was reviewed.

Progress note entry dated for a specified day by a registered nursing staff member indicated that a PSW had reported that the resident was moving in bed on his/her own very well and was frequently repositioned on one side to be later found on the other side of the bed. A month prior to this, there is another note, dated on a specified day, that indicated that the resident was restless and required frequent

repositioning.

On a specified day in November 2016 an interview with the SDM described the resident as restless at night, able to move around, "wiggling" around in bed.

On November 15, 2016 during an interview with inspector #548, PSW #115 and PSW #108 indicated pillows are used regularly to reposition the resident and on November 23, 2016 this was confirmed with PSW #115. On November 18, 2016 the DOC indicated that the resident is positioned with the use of pillows due to contractions to appendages. The resident has a ZR mattress-with perimeter edge, #M79, to deter movement in bed.

On November 18, 2016 the DOC indicated that fall prevention interventions include: the use of the ¼ rails, fall device in place (mattress pad alarm), fall mat along bedside and bed at the lowest position.

The home's policy, Resident Safety, NURS 5-10, Approval date: April 2013 specifies that all hi-low beds are placed in the lowest position to optimize resident safety. The home places all beds to their lowest point as stated in the policy. On November 24, 2016 the ADOC indicated that beds are placed to the lowest position as a general practice for all residents at the home.

The plan of care was not reviewed to clearly indicate that the resident was a fall risk and moved independently in his/her bed. The resident was not assessed for the need of the bed to the lowest position related to fall risk interventions and his/her change in mobility while in bed. In addition, pillows were used and not identified as repositioning aids or possible fall prevention interventions for resident #010. As well, Blue posey boots were implemented without an assessment of need. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

Issued on this 3 day of January 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : RUZICA SUBOTIC-HOWELL (548) - (A1)

Inspection No. / No de l'inspection : 2016_287548_0029 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 032133-16 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jan 03, 2017;(A1)

Licensee / Titulaire de permis :
DUNDAS MANOR LIMITED
533 CLARENCE STREET, P.O. BOX 970,
WINCHESTER, ON, K0C-2K0

LTC Home / Foyer de SLD :
DUNDAS MANOR NURSING HOME
533 CLARENCE STREET, P.O. BOX 970,
WINCHESTER, ON, K0C-2K0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Norm Slatter

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

Ministère 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 DUNDAS MANOR LIMITED, 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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is hereby ordered to eliminate the safety hazards associated with the use of baseboard heaters by:
1. Establishing clear policies, procedures and monitoring processes related to the use of baseboard heaters in areas accessible to residents.
2. Conducting a record of an assessment of each individual resident to determine the appropriate placement of the bed in relation to the baseboard heater, based on the identified needs of the resident.
3. Carrying out regular, documented audits to ensure that the placement of the bed in relation to the baseboard heater continues to meet the safety needs of the resident, especially if the needs of the resident have changed since the last audit.

Grounds / Motifs :

1. A critical incident report was submitted to the MOHLTC on an identified day in 2016. Resident #010 was found wrapped in a top sheet with an appendage to be resting on the base board heater (BBH).

The initial assessment described an injury to the appendage.The injury was treated by RPN #101 who discovered the resident #010 and indicated that she was not certain what had caused the injury.

At approximately 0700 hours RN #111 and RPN #107 assessed the appendage and

notified the physician and Substitute decision-maker (SDM).

Resident #010 was transferred to hospital with an altered skin integrity of unknown origin. Upon assessment it was determined that the resident be transported to another hospital for specialized care related to the injury.
The health care record and the home's investigative notes were reviewed related to the critical incident report.

The Resident #010 requires extensive assistance for all activities of daily living. The day prior to the incident the post bath assessment indicated that there were no identified alterations in the resident's skin integrity to the affected area. This was later confirmed during an interview on November 9, 2016 with PSW #102 who gave the resident's bath.

On November 9, 2016 during an interview RPN# 101 indicated to inspector #548 that when she entered the room she found the resident's upper torso to be partially on the bed on the mattress pad alarm and the resident's appendage to be resting on the (BBH). She removed the resident from the (BBH) and treated the area. In discussion, RPN #101 indicated that she found the room to be "overly hot" and noted that the thermostat dial was past the number 25. The thermostat is affixed on the wall adjacent to resident bed and the unit is composed of a dial affixed to a box anchored to the wall. There are numbers on the unit. She readjusted the thermostat lowering the temperature and the resident was monitored by staff for the remainder of the shift.

On November 9, 2016 during an interview with inspector #548, PSW #102 indicated that at the time of the incident the resident's #010 bed was close to the (BBH). Staff were unable to walk alongside the bed on the side of the BBH to provide care having to shuffle their feet one in front of another.

On the same day, November 9, 2016, RPN #101 concurred that it was difficult to move along the (left) side the bed due its proximity to the (BBH) and window. Additional interviews conducted with: ADOC #103, maintenance supervisor #100, PSW #102, SDM, RN #111 and PSW #115; they all indicated that the bed was close to the (BBH) "for a period of time" or "since the resident's admission to the room". The resident was admitted to an identified room on a specified date in 2016. From the DOC's investigative notes dated November 8, 2016 PSW #106 indicated that the bed was in the same position, close to the window, since the resident's admission to

the room.

In the resident's room, the thermostat is affixed on the wall adjacent to resident bed. The thermostat unit is composed of a dial affixed to a box anchored to the wall. The dial has inscribed lines, numbers and dots around a dial. The dial was easily manipulated by the inspector #548 from number 0 to 25. The word Celsius is at the six o'clock location on the unit. The maintenance supervisor #100 confirmed that when the dial is placed at the three o'clock position the thermostat reading is at 30 degrees Celsius. Inspector #548 accessed and easily adjusted the temperature dial on the thermostat. On November 10, 2016 during an interview with the inspector #548 the maintenance supervisor #100 indicated he makes weekly rounds of each resident`s room to adjust the thermostat and noted that the resident's bed was parallel to and in "close" proximity to the (BBH). Maintenance supervisor #100 provided to the inspector #548 record of the weekly rounds completed a few days before the incident. For resident's #010 room he indicated that the bed side table was on the right hand side of the bed and the bed was "close" to the (BBH). The (BBH) is located on the left side of the resident's bed. Residents are provided a bed, bed side table and chair. Discretion is given to residents and/families to configure these items in resident rooms. Of the staff interviewed, above, they acknowledged that there are several other residents whose beds were "close" to the (BBH). On November 9, 2016 it was observed by inspector #548 additional rooms on the unit that each resident bed is parallel to the (BBH). Post incident the maintenance supervisor indicated that he measured the distance of the bed from the heater, length of (BBH) and thermostat accessibility in each resident room. Record of this measurement on the unit indicated that those beds were 10 inches away from the (BBH). He indicated that he could not measure the resident's room as the bed had been moved away from the (BBH), post incident.

The resident was admitted and interviewed staff were aware of the bed placement in relation to the room's baseboard heater since the resident's admission to the room. There was no assessment conducted to determine optimal environmental safety for resident #010.
(548)

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

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

Ministère 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

Dec 27, 2016

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 is hereby ordered to complete the following:
1. Develop a bed safety questionnaire to include a "Bed Safety Checklist for resident use" to include all relevant questions and guidance related to bed safety hazards found in the: Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document and Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards. The questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. while the resident is sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors; positioning aids or accessories, prior to the application of any bed rails; and

b. the alternatives that were trialed prior to using one or more bed rails and document whether the alternatives were effective or not during an observation period.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the safety questionnaire developed above and document the assessed results and recommendations for each resident.

3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the bed safety questionnaire. Include in the written plan of care any necessary accessories that may be required to mitigate any identified bed safety hazards.

4. The licensee is to review and revise the policy: Resident Safety, NURS 5-10, Approval date: April 2013 to be consistent with the above developed questionnaire, related to all resident's needs for a low bed.

5. The licensee will ensure the revise policy, above, is complied with.

Grounds / Motifs :

1. TThe Licensee failed to ensure that where bed rails are used the resident is

assessed and his or her bed system is evaluated in accordance with evidenced-based practise and, if there are none, in accordance with prevailing practises, to minimize risk to the resident.

Related to the critical incident report above.

The resident #010 was admitted to the home on an identified date into a specified room, then moved on two separate occasions to other resident rooms. The last transfer was done on a specified date to the resident's current identified bed - bed room.

The home provided documentation titled: Entrapment Inspection dated January 2016 on beds-in-use at the home. The bed number and make, mattress type and number, if the mattress has a perimeter edge, location of bed frame and mattress by room and bed number and, individual columns titled Zones 1 through 7.

The home has several different types of mattresses: Zenith Regular, Zenith TriGel, Span Geo, MC Health, Zephair, Other Air and STG-IV. The home's bed frame types are MC and Invacare. The MC bed frame comes with either wheels tucked up or with wheels down as confirmed by maintenance worker #104.

It is recorded in the above document that the resident's bed number is 62, bed model is MC with a ZR mattress-with perimeter edge. The mattress number is recorded as M79. There are check marks in each column for zones 1 to 7.

On November 18, 2016 at approximately 10:30 inspector #548 and #133 entered the resident's room.
Maintenance workers #104 and #112 explained they were installing a full rail on the right side of the resident's bed; as per family request. Maintenance worker #104 indicated that the mattress followed the resident from her initial admission to each room location. Maintenance supervisor #100 indicated that each bed system is measured on an annual basis and the results recorded in the Entrapment Inspection document. He indicated that the zones were checked by the home and the checkmarks in the columns titled zones 1 through 7 indicated that the bed system passed the evaluation. The maintenance supervisor confirmed resident's #010 mattress was moved from one room to the present room existing bed frame, with no evaluation of the resulting bed system.

The Health Canada guidance document, Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, Effective Date: 2008/03/17 (HC guidance document) goal is to reduce potential life-threatening entrapments associated with bed systems involving an interdisciplinary approach that includes the bed design, clinical assessment and monitoring and, meeting family and resident needs. All long-term care homes were directed to use this as a best practice document in 2012 by the Director under the LTCHA 2007. Bed rails are an integral component to the bed system and the HC guidance document speaks to the need to assess residents for risk related to bed rail use. As endorsed by the guidance document the current prevailing practices; "Clinical Guidance For The Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003" provides guidance for the assessment of the resident where bed rails are used.

The clinical guidance document describes that the individual resident assessment be a documentation of the risk-benefit assessment and be available within the health care record. The clinical guidance document describes the assessment to include individual resident assessment, sleeping environment assessment and treatment programs/care plans.

In discussion with inspector's #548 and #133 on November 18, 2016 with the DOC she indicated that the beds at the home are equipped with ¼ bed side rails at the head of the bed. She further reported that all residents are not assessed for the need and use of bed rails and the use of bed rails is not care planned. Bed rails are used automatically by staff in the home. The home conducts standardized bed assessments however, resident's #010 bed was
(548)

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

Feb 06, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

1. The resident's #010 bed safety is to be reassessed when there is a change in resident condition. This includes and is not limited to bed height, use of sides rails as evaluated in the questionnaire related to the bed system and, is to be documented.

2. All resident's sleep patterns, bed mobility, use of positioning aides needs are to be assessed when there is a change in condition, interventions put into place and re-evaluated when these interventions to keep them safe is ineffective. The provisions, outcomes and effectiveness are to be documented in the plan of care.

3. All registered nursing staff are to be provided education on how to reassess resident's when their care needs change, such as mobility in bed, or when care set out in the plan is no longer necessary or, has not been effective.

4. The licensee shall ensure that the plan of care for all residents is reviewed and revised to determine clear directions to staff and others who provide direct care in respect to bed height and repositioning aids.

Grounds / Motifs :

1. The Licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or the care set out in the plan is no longer necessary.

Related to the critical incident report above.

The resident #010 is dependent on staff for activities of daily living and is identified as a high risk for falls.
The resident was found on the floor at the bedside on the three separate occasions in 2016. Review of the three post-fall assessments indicated that the resident #010 attempted to crawl or get out of bed. Fall interventions specified in the October 2016 care plan calls for the use of a mattress pad alarm and the resident was placed on the home's falling leaf program. The resident uses a mechanical lift, two person assistance for transfers and mobilizes with use of a wheelchair.

The health record was reviewed.

Progress note entry dated for a specified day by a registered nursing staff member indicated that a PSW had reported that the resident was moving in bed on his/her own very well and was frequently repositioned on one side to be later found on the other side of the bed. A month prior to this, there is another note, dated on a specified day, that indicated that the resident was restless and required frequent repositioning.

On a specified day in November 2016 an interview with the SDM described the resident as restless at night, able to move around, "wiggling" around in bed.

On November 15, 2016 during an interview with inspector #548, PSW #115 and PSW #108 indicated pillows are used regularly to reposition the resident and on November 23, 2016 this was confirmed with PSW #115. On November 18, 2016 the DOC indicated that the resident is positioned with the use of pillows due to contractions to appendages. The resident has a ZR mattress-with perimeter edge, #M79, to deter movement in bed.

On November 18, 2016 the DOC indicated that fall prevention interventions include:

the use of the ¼ rails, fall device in place (mattress pad alarm), fall mat along bedside and bed at the lowest position.

The home's policy, Resident Safety, NURS 5-10, Approval date: April 2013 specifies that all hi-low beds are placed in the lowest position to optimize resident safety. The home places all beds to their lowest point as stated in the policy. On November 24, 2016 the ADOC indicated that beds are placed to the lowest position as a general practice for all residents at the home.

The plan of care was not reviewed to clearly indicate that the resident was a fall risk and moved independently in his/her bed. The resident was not assessed for the need of the bed to the lowest position related to fall risk interventions and his/her change in mobility while in bed. In addition, pillows were used and not identified as repositioning aids or possible fall prevention interventions for resident #010. As well, Blue posey boots were implemented without an assessment of need.
(548)

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

Feb 06, 2017(A1)

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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

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

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

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

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

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 3 day of January 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RUZICA SUBOTIC-HOWELL - (A1)

Service Area Office /
Bureau régional de services : Ottawa