Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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
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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
Mar 15, 2016	2016_189120_0011-A1	027828-15	Follow up

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE HAMILTON
90 CHEDMAC DRIVE HAMILTON ON L9C 7S6

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): March 2, 2016

An inspection (2015-337581-0014) was previously conducted between July 28 and August 17, 2015. Order #003 was issued on September 1, 2015 related to clinical bed safety assessments. The compliance date for the Order was November 30, 2015. The conditions that were laid out in the order have not all been met. See below for outstanding conditions.

During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care.

During the course of the inspection, the inspector reviewed the written plan of care for 5 randomly selected residents, bed safety entrapment audits, clinical bed rail use assessments, the licensee's bed rail use policy and associated forms.

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 where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be evaluated by an interdisciplinary team, over a period of time, while in bed, by answering a series of questions to determine if the bed rail is a safe device for resident use. The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or their SDM (Substitute Decision Maker) about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A) The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as

identified in the above guideline. According to the licensee's policy titled "Use of Bedrail Devices, April 2011", no reference was made to the above noted guideline. According to the Director of Care, the guideline was not reviewed by herself or her registered staff (assessors) and therefore not incorporated into their process of reviewing hazards associated with bed rail use. A condition laid out in the previous Order issued on September 1, 2015 required that the clinical bed rail use assessment process be developed using the information identified in the above noted guideline.

The forms used by the assessors included the Bed Rail Device Assessment Survey (Appendix III), the PASD/Restraint Form and the Bed Rail Decision Tree (Appendix II). None of the questions on the forms were geared towards assessing safety issues such as potential rail injuries (banging into or against the rail), sleeping habits (if next to a rail and along edge of bed), strangulation, suffocation, accidental suspension off the side of the bed or tendency to climb over the rails. According to the Administrator, an interdisciplinary team was involved in assessing each resident for rail use, however the assessment was based on limited questions geared to cognition, mobility and transfer capabilities which were included on the PASD/Restraint form.

B) During the tour through the 3 home areas on the 2nd floor, observations were made that approximately 40% of resident beds had at least one bed rail raised (1/4 length rail) or at least one rotating assist rail in the guard position (centre of bed). The residents did not all occupy their beds at the time of the observation. To confirm the need for bed rails to be engaged or "raised" while residents were out of bed, the residents' written plans of care were reviewed.

Resident #001 was not in bed at time of observation and their right side 1/4 length bed rail was in the raised position. The resident's written plan of care revealed that both "assist" bed rails were to be used while the resident was in bed for repositioning. No information was available regarding the need for the bed rail to remain in the raised position at any other time. Discussion was held with the Administrator regarding the confusion in the rail type and length identified on the written plan of care compared to what was actually observed to be on the bed during the inspection.

Resident's #002 and #003 were not in bed at time of observation and each bed had one bed rail in the guard position. The bed rail for resident #003 was covered by a blanket. The residents' written plan of cares revealed that both residents required an "assist" bed rail while in bed for repositioning. No information was available regarding the need for a bed rail to remain in the raised position at any other time for either resident.

According to the Director of Care, personal support workers were not given any education with respect to bed rail hazards and ensuring that they followed the written plan of care for direction in applying a bed rail (medical device) since the last inspection between July 28 and August 17, 2015. A condition laid out in the previous Order issued on September 1, 2015 required that all health care staff be provided with education with respect to when to apply bed rails for each resident, why they were being applied and general bed safety hazards. [s. 15(1)(a)]

Additional Required Actions:

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

Issued on this 15th day of March, 2016

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2016_189120_0011
Log No. / Registre no:	027828-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 15, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE HAMILTON 90 CHEDMAC DRIVE, HAMILTON, ON, L9C-7S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pilar Henderson

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_337581_0014, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1. Develop or amend existing clinical bed rail use safety questionnaires and decision making documents to include additional questions related to bed rail safety as identified in the guidelines identified in the US Food and Drug Administration's (FDA) 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. All staff who are or will be involved in clinically assessing the residents for bed rail use shall be familiar with the guidelines identified in the FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".

3. Re-assess all residents who use one or more bed rails by employing the amended bed rail use safety questionnaire developed in #1 above and document any changes related to the use of their bed rail(s) in their written plan of care.

4. All staff who provide care to residents shall receive education on the hazards of bed rail use, when to apply a bed rail, why bed rails are applied and be made aware of their role in reporting bed rail entrapment, injury or near misses to registered staff.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be evaluated by an interdisciplinary team, over a period of time, while in bed, by answering a series of questions to determine if the bed rail is a safe device for resident use. The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, behaviours,

medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or their SDM (Substitute Decision Maker) about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A) The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified in the above guideline. According to the licensee's policy titled "Use of Bedrail Devices, April 2011", no reference was made to the above noted guideline. According to the Director of Care, the guideline was not reviewed by herself or her registered staff (assessors) and therefore not incorporated into their process of reviewing hazards associated with bed rail use. A condition laid out in the previous Order issued on September 1, 2015 required that the clinical bed rail use assessment process be developed using the information identified in the above noted guideline.

The forms used by the assessors included the Bed Rail Device Assessment Survey (Appendix III), the PASD/Restraint Form and the Bed Rail Decision Tree (Appendix II). None of the questions on the forms were geared towards assessing safety issues such as potential rail injuries (banging into or against the rail), sleeping habits (if next to a rail and along edge of bed), strangulation, suffocation, accidental suspension off the side of the bed or tendency to climb over the rails. According to the Administrator, an interdisciplinary team was involved in assessing each resident for rail use, however the assessment was based on limited questions geared to cognition, mobility and transfer capabilities which were included on the PASD/Restraint form.

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Resident #001 was not in bed at time of observation and their right side 1/4 length bed rail was in the raised position. The resident's written plan of care revealed that both "assist" bed rails were to be used while the resident was in bed for repositioning. No information was available regarding the need for the bed rail to remain in the raised position at any other time. Discussion was held with the Administrator regarding the confusion in the rail type and length identified on the written plan of care compared to what was actually observed to be on the bed during the inspection.

Resident's #002 and #003 were not in bed at time of observation and each bed had one bed rail in the guard position. The bed rail for resident #003 was covered by a blanket. The residents' written plan of cares revealed that both residents required an "assist" bed rail while in bed for repositioning. No information was available regarding the need for a bed rail to remain in the raised position at any other time for either resident.

According to the Director of Care, personal support workers were not given any education with respect to bed rail hazards and ensuring that they followed the written plan of care for direction in applying a bed rail (medical device) since the last inspection between July 28 and August 17, 2015. A condition laid out in the previous Order issued on September 1, 2015 required that all health care staff be provided with education with respect to when to apply bed rails for each resident, why they were being applied and general bed safety hazards. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2016

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

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 sions de longue durée
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
Inspection de sions de longue durée
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 15th day of March, 2016

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