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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 9, 2017	2017_625133_0008	007372-17	Critical Incident System

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 LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 11,12,13, 18, 19, 20, 21, 24 - 2017

This Critical Incident System inspection was conducted in relation to a resident's unexpected death.

During the course of the inspection, the inspector(s) spoke with the Extendicare Regional Director with responsibility for the home, the Extendicare acting clinical coordinator for the home, the Administrator, the Director of Care, the Assistant Director of Care, the acting Assistant Director of Care, the home's Medical Director, the Support Services Manager, a maintenance worker, registered and non-registered nursing staff and residents.

The Inspector reviewed the Critical Incident Report that was submitted by the home in response to a resident's unexpected death. The Inspector interviewed staff who found the resident at the time of the incident. The Inspector observed residents' bed systems. The Inspector reviewed resident health care records, manufacturer's instructions related to the use of specified bed alarms and personal alarms, manufacturer specifications related to maintenance of a specified brand of bed system, and documentation related to bed system evaluations in the home.

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

On an identified date in April 2017, resident #001 was found by Personal Support Worker #S116 in his/her bedroom with certain body parts in contact with the bed system and certain body parts not in contact with the bed system. Registered nursing staff on the unit were alerted and attended the room. Upon further assessment, resident #001 was determined to have no vital signs and the on-call physician and coroner were notified of the unexpected death.

On April 11th, 2017, the home's Administrator informed the Inspector that there had been a chair alarm in use for resident #001 in bed (referenced as a personal alarm) and that the cord was still attached to resident #001's clothing when he/she was found. As well, the Administrator informed the Inspector that there had been a bed alarm in use for resident #001.

The Inspector reviewed the manufacturer's instructions for what had been referenced as a chair alarm by the Administrator, the Curbell Medical CareSense Personal Monitor, as provided by the home's Support Services Manager (SSM). In the "Safety Information" section, the third warning was as follows "NEVER use if the monitor cannot be securely mounted to the wheelchair, headboard or door bracket". This device will be referenced below as a personal alarm or PA.

The Inspector reviewed the manufacturer's instructions for the bed alarm, the Curbell Medical Cordless Advanced Bed and Chair Monitor, as provided by the home's SSM. In the "Installing the Batteries" section, point #3 was as follows: always use new alkaline batteries and replace them all at the same time. Do not mix battery types/brands. As well, in the "Mounting the Monitor" section, there was the following warning: "NEVER use the monitor if it cannot be securely mounted". This device will be referenced below as a bed alarm or a BA.

Related to the placement of the personal alarm (PA) monitors when in use for a resident in bed, including resident #001:

On April 12th, 2017, in the presence of the Administrator, Registered Nurse (RN) #S104 explained to the Inspector that she had found the PA cord clipped to resident #001's back left upper shoulder area on the identified date of the resident's unexpected death. The RN confirmed that the clip had not detached from the PA monitor and that there was no alarm. The RN could not recall where the PA monitor was when she unclipped the cord from resident #001, but noted that it had moved with the resident. The RN indicated that sometimes the Personal Support Workers (PSWs) will place the PA monitors under a

resident's pillow, but that it depends on the individual, and sometimes the PA monitor is placed next to the resident on the mattress up towards the headboard. The Administrator directed the RN to follow up with staff about placement of the PA monitors, as they should be placed on the headboard.

RN #S104 sought out the Inspector, at approximately 17:50 hours on April 12th, 2017, to inform that she had spoken with a group of PSWs about placement of the PA monitors. The RN explained that the PSWs had informed her that the clip on the back of the PA monitors is too tight and does not allow it to be secured to a headboard. RN #S104 and the Inspector went to resident #001's bedroom, and the RN demonstrated that the PA monitor could not be clipped to the headboard.

On April 12th, 2017, PSW #S109 explained to the Inspector that in the past, PSWs attached the PA monitors to residents' bed rails with a Velcro strap. The PSW explained that as the Velcro straps went missing over the last few years, they were never replaced. The PSW explained that there was one resident (#005) on a specified unit that still had a Velcro strap attached to her/his PA monitor and that it was strapped to resident#005's bed rail when the resident was in bed. The PSW indicated that she will normally put the PA monitor under a resident's pillow, and when the resident moves, she finds that the PA cord normally detaches from the monitor. The PSW indicated she may also put the PA monitor between the headboard and the mattress.

On April 12th, 2017, PSW #S110 explained to the Inspector that she puts the PA monitor under a resident's pillow. The PSW indicated that when the resident moves, the cord does not disconnect. The PSW explained that the new beds have thicker headboards, and the clips on the back of the PA monitors do not fit the headboards. The PSW estimated that it had been about 3 years since they've had the new beds.

On April 13th, 2017, the Director of Care (DOC) showed the Inspector a new PA, still in its packaging. It was noted that a Velcro strap was included with the package. The DOC explained her understanding that only sometimes would a PA be used for a resident in bed, and that she would prefer that bed alarms be used for this purpose. The DOC indicated that if a PA was to be used for a resident in bed, the PA monitor would be attached to the bed with Velcro or with the clip on the back of the monitor. The DOC indicated that if staff put the monitor beside the resident in the bed, there would be no purpose to it, as the monitor needs to be attached to something.

On April 18th, 2017, the acting Assistant Director of Care (aADOC) explained to the

inspector that her understanding was that for a few residents, PSWs would use the PA in the bed. The aDOC qualified that she understood that this would be done only for a short period, such as if there was something wrong with the resident's bed alarm. The aADOC explained that she used to work on the 3rd floor prior to steeping into her current role in December 2016. The aADOC indicated that when she was on 3rd, it was not supposed to be the practice that PSWs would use a PA for a resident in bed, but she did see it happen. The aADOC said that she had observed that PSWs would put the PA monitor on the residents' mattress, above the pillow.

On April 18th, 2017, PSW #S112 explained to the Inspector that when she uses a PA for a resident in bed, the monitor goes under the pillow or near the pillow. The PSW indicated that it had always been like that, as the PA monitor clips are too tight to fit onto the bedframes.

On April 18th, 2017, PSW #S113 confirmed to the Inspector that she had put resident #001 to bed after his/her last meal on the identified date of the resident's unexpected death. PSW #S113 explained that she had attached the PA cord to resident #001's upper back shoulder area, and the monitor was in the bed, close to the pillow.

On April 19th, 2017, PSW #S115 confirmed to the Inspector that after resident #001 was initially found, by another PSW, she was one of the first to see the resident on the date of the resident's unexpected death. PSW #S115 confirmed that the PA cord was still attached to resident #001 and the PA monitor was in the bed. PSW #S115 said she could understand that the PA did not go off because the monitor had moved along with the resident.

On April 19th, 2017, PSW #S116 confirmed to the Inspector that she had found resident #001 on the identified date of the resident's unexpected death. PSW #S116 explained that she had noticed that resident #001's PA was clipped to him/her, the monitor was in the bed, and everything was intact.

On April 20th, 2017, Registered Nurse (RN) #S117 indicated to the Inspector that when a PA is in use for a resident in bed, most of the time she sees the monitor under the pillow to hide it so the resident cannot see it.

On April 20th, 2017, the Extendicare Regional Director with responsibility for the home indicated that the PA that was in use for resident #001 had served no purpose because the monitor was not secured to anything. He indicated that he thought it may be best not

to use the PAs for residents in bed.

On April 20th, 2017, the Assistant Director of Care (ADOC) informed the Inspector that she had been in her position since September 2015. Prior to that, she had been worked as the RN on 2nd, 3rd and 5th floors. The ADOC explained that when she was on the floors, PAs would follow a resident from their wheelchair to their bed, and the PA monitors would be put under the residents' pillow. The ADOC indicated that she does not see any PA monitors with Velcro now, noting that the PAs that used to be in use in the home were smaller, a little rectangle, and they all had very thick Velcro on them. The ADOC noted the PAs in use now are very heavy, and since they have been in use, PSWs have been tucking them somewhere into the bed as they do not have the Velcro like they used to. The ADOC indicated that she had never raised this issue as a concern to the Director of Care because she never understood that it was a problem. The ADOC indicated that she now understood that putting the PA monitors in the bed with the residents does not make sense. The ADOC informed that they would be moving away from using the PAs for residents in bed, once all residents who required it were provided with a bed alarm.

On April 20, 2017, the Director of Care (DOC) confirmed to the Inspector that a decision had been made to stop using PAs for residents in bed. The DOC informed that a list of all residents with PAs or bed alarms (BAs) in use had been compiled, and that all BA monitors had been affixed with Velcro to the residents' bed footboards. The DOC explained that more BAs would be ordered, with bed mounting brackets, so that residents who only had a PA could also be provided with a BA if it was needed for them ir bed. As per the list compiled, there was approximately 50 residents in the home with a PA. Resident #002 was identified as one of the residents for which a BA was being ordered.

The Inspector observed resident #002 in her/his bed while awake and while sleeping, on April 21, 2017. There was a PA cord attached to the resident's upper back shoulder area and the monitor was on the mattress next to the pillow. Progress notes were reviewed for resident #002, for the period of January 1, 2017 to April 21, 2017. There was 12 documented occasions where resident #002 had been found by nursing staff to have exited the bed unattended. Twice the resident was found with certain body parts in contact with the bed system and certain body parts not in contact with the bed system.

On April 21, 2017, the DOC informed the Inspector that 40 BAs had been ordered. The DOC indicated that since her and the Inspector had first discussed this issue, she had

realized that she had seen PAs being used in bed for residents but had not thought much about it. The DOC indicated that she now understood that the way the PAs were being used for residents in bed was not serving a purpose.

Related to resident #001's bed alarm (BA) monitor and batteries:

On April 12th, 2017, maintenance worker #S107 unscrewed and removed the battery cover on the bed alarm monitor that had been in use for resident #001. It was observed that there were two different sets of batteries, two orange Duracell Procell batteries and two black and silver Energizer Industrial batteries. The maintenance worker stated that all batteries are supposed to be replaced at the same time, and that the same type and brand of batteries are to be used. The maintenance worker indicated that the orange Duracell batteries are used by the maintenance department, while the black and silver Energizer batteries are used by the nursing department.

On April 20th, 2017, in discussion with the Administrator, Director of Care and Assistant Director of Care, it was confirmed that the nursing department uses the same orange Duracell Procell batteries that are used by the maintenance department. It was noted however that the black and silver Energizer Industrial batteries are ordered for use with IV pumps.

On April 21, 2017, RN #S104 showed the Inspector a box of black and silver Energizer Industrial batteries, for use with IV pumps, in the 3rd floor nurses' station "dressing for East side" upper cupboard.

Related to the placement of bed alarm (BA) monitors:

On April 13th, 2017, PSW #S111 explained to the Inspector that she had given resident #001 a snack, after the resident's last meal, on the identified date of the resident's unexpected death. The PSW told the Inspector that she remembered seeing the BA monitor on the bed side table.

On April 18th, 2017, PSW #S112 told the Inspector that when she uses a BA for a resident, the monitor is always placed on the bed side table.

On April 19th, 2017, PSW #S115 confirmed to the Inspector that when a BA is in use for a resident, the monitor is on the bed side table.

On April 19th, 2017, PSW #S116 confirmed that when a BA is in use for a resident, the monitor is on the bed side table.

On April 20th, 2017, maintenance worker #S107 explained to the Inspector that the BAs currently in use in the home have been in use for many years and that the monitors have always been placed on the bed side tables. Maintenance worker #S107 explained that once he has programed a BA monitors to an alarm pad, they are brought to the nurses' station and it is nursing staff that put them into place.

On April 20th, 2017, the Administrator informed the Inspector that there had been discussion with the management team in recent morning reports, following the death of resident #001, regarding the need for PA monitors and BA monitors to be securely mounted. The Administrator noted that having the PA monitor in the bed with a resident serves no purpose and indicated that she had never seen this done before. The Administrator noted that if a resident was sliding down the bed trying to get up or scooting down the bed trying to get out, the PA monitor will just move with the resident and not activate. Later that day, the Director of Care reported to the Inspector that all BA monitors had been attached to the foot of the residents' beds with Velcro.

The licensee has failed to ensure that staff use the Curbell Medical CareSense Personal Monitor in accordance with manufacturers' instructions, specifically related to the placement of the monitors when they are in use for a resident in bed.

The licensee has failed to ensure that staff use Curbell Medical Cordless Advanced Bed and Chair Monitors in accordance with manufacturers' instructions, specifically related to the placement of the monitors, and, with regards to resident #001's monitor, related to the use of battery types.

The scope of the non-compliance described above is widespread as it applies to all residents with a personal alarm monitor in use when in bed and all bed alarm monitors. The non-compliance presents potential risk of harm to the residents. A compliance order will be issued. [s. 23.]

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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that residents' bed systems are maintained at a level that meets manufacturer specifications.

On April 20th, 2017, the SSM informed the Inspector that he had completed entrapment zone testing for all bed systems with half rails on them, also known as assist rails, with the rails in the "up" position. The SSM had previously informed the Inspector, on April 11, 2017, that these bed rails had only been tested in the "down" position. The SSM noted that he had found that some of the bed rails needed to be tightened. He qualified that the bed rails had passed the initial entrapment zone testing, but there was some play when he jiggled them, and he wanted them all to be as tight as possible. The SSM referenced two residents' bed rails that had required a change of hardware, which was done by maintenance staff, as the SSMs initial tightening of the hardware did not solve the problem. As discussed and as per the worksheet that the SSM had made notes on while testing the bed rails, titled "Half Assist Rails", of the 50 residents' beds that were tested, 13 required tightening of one or both bed rails. As discussed and as per the worksheet, 34 of the 50 residents' beds that were checked were CS series beds. The SSM confirmed that these beds were the majority in the home. As per the SSM's bed entrapment worksheet, on which the results for all entrapment zone testing for all residents' beds was documented, 203 of 242 beds in the home were CS series beds.

As per the Invacare CS Series Beds CS3, CS5, CS7, CS9FX600 User Manual, annual maintenance checks are prescribed. Required checks include, but are not limited to, the following: Inspect rail latches. Ensure that all rails engage and lock as specified; Inspect rails for wear and damage and replace as required.; Lubricate rail pivot points as

needed.; Tighten, adjust or replace any parts or bolts etc. that are loose or show signs of wear. As well, a warning in the Annual Maintenance Check section indicates "When evaluating the condition of rail attachments it is necessary to consider all aspects of the bed-rail system, including consideration of the rails, mattress, and bed system. Refer to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment published by the U.S. Department of Health and Human Services Food and Drug Administration."

The Inspector reviewed the "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" document referenced in the CS series user manual and found that it mirrored the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". These documents characterize, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4). On August 21, 2012, a notice was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, directing that the Health Canada guidance document was to be used as a best practices document.

Over the course of the inspection, the SSM confirmed that there had not been an annual process in place to evaluate bed systems with regards to bed rails and the potential entrapment zones. The SSM had indicated that all 242 residents' bed systems were evaluated in October 2014. Since that time, the SSM approximated that 80 new beds had come into the home and he confirmed that they had been evaluated. The SSM indicated that in addition to the new beds, he had re-evaluated approximately a quarter of the residents' bed systems since October 2014. As well, the SSM indicated that he had evaluated bed systems where there may have been a concern about resident entrapment. As a result of the SSM's record keeping method with regards to bed system evaluation, it could not be determined when a bed system had last been evaluated.

On April 24, 2017, the SSM confirmed to the Inspector that there had not been a preventative maintenance program in place for residents' beds. It was confirmed that staff were expected to report any problems they became aware of in relation to a resident's bed. Manufacturer specifications for annual maintenance checks for the CS series beds were discussed. The SSM informed that an annual bed system evaluation

process would be implemented that would encompass manufacturer specifications, including entrapment zone testing and all specified maintenance checks.

On May 2, 2017, the Administrator confirmed to the Inspector that the licensee did not have a procedure developed to ensure that resident bed systems are maintained at a level that meets manufacturer specifications.

The licensee has failed to ensure that procedures are developed to ensure that resident bed systems are maintained at a level that meets manufacturer specifications, at a minimum.

The scope of the non-compliance described above is widespread as it applies to all residents' beds in the home. The non-compliance presents potential risk of harm to the residents. A compliance order will be issued. [s. 90. (2) (a)]

Additional Required Actions:

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

WN #3: 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 has failed to ensure that where bed rails are used, 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.

On August 21, 2012, a notice was issued to Long Term Care (LTC) Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the notice, it is written that the Ministry expects homes to use the Health Canada Guidance Document as a best practice document in their home. The Health Canada (HC) guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

Related to resident assessment:

The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the HC Guidance Document are identified as useful resource and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment for residents where bed rails are used. In this document, it is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including, but not limited to, the resident’s right to participate in the care planning process, the resident’s medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. The

document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

As a result of Resident Quality Inspection # 2017_658178_0002, that began on February 21, 2017 and concluded on March 13, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1). The compliance order was served on April 7, 2017, and was specifically related to the assessment of residents in accordance with prevailing practices, where bed rails are used, to minimize risk to the resident. The grounds that support the order detail that it was determined by Long Term Care Home Inspector #138 that no resident in the home with bed rails in use had been assessed in accordance with prevailing practices. As well, it was determined that every bed in the home had some type of bed rails.

The following non-compliance, related to resident assessment, is issued as additional information in support of the compliance order.

Related to resident assessment, specific to resident #001:

On an identified date in April 2017, resident #001 was found by Personal Support Worker #S116 in his/her bedroom with certain body parts in contact with the bed system and certain body parts not in contact with the bed system. Registered nursing staff on the unit were alerted and attended the room. Upon further assessment, resident #001 was determined to have no vital signs and the on-call physician and coroner were notified of the unexpected death.

As observed by the Inspector on April 11, 2017, resident #001 had a bed system which included two bilateral quarter bed rails.

On April 11th, 2017, the Administrator confirmed that the bed rails were in use for resident #001. The Administrator qualified that the bed rails were not in use as a personal assistance services device (PASD) or as a restraint, they were just in use.

On April 11th, 2017, Registered Nurse (RN) #S104 indicated her understanding that bed rails were in use for resident #001 to prevent falls, and explained that all residents in the home have bed rails in use. The RN noted that resident #001 used the bed rails to change his/her position in bed.

On April 18th, 2017, the acting Assistant Director of Care (aADOC) indicated that there had been no express decision to apply the bed rails for resident #001 and explained that they were in use as they were on the bed that resident #001 was in. The aADOC noted that generally, they were not choosing bed rails for the residents. She explained that residents were accepted into a bed and as there are bed rails on all of the beds, they would then be used for the resident.

On April 20th, 2017, the Assistant Director of Care (ADOC) indicated that bed rails were in use for resident #001 because bed rails are used for all residents in the home. The ADOC explained that residents are admitted into the bed that was in the room before they were admitted, and there has not been consideration of if the resident needs the rails or not.

Related to resident assessment, specific to resident #002, #003 and #004:

As previously established, no resident in the home with bed rails in use had been assessed in accordance with prevailing practices, to minimize risk to the resident.

On April 13, 2017, the home's Support Services Manager (SSM) informed the Inspector that he had performed entrapment zone testing on resident #002, #003 and #004's bed systems, all of which included a therapeutic air surface. The SSM informed that the three residents' bed systems had failed the entrapment zone testing, in relation to zone 2 and zone 3. The SSM confirmed that bed rails were in use for these three residents.

As noted in the HC guidance document, therapeutic air surfaces "are easily compressed by the weight of patient and may pose additional risk of entrapment when used with conventional hospital bed systems. When these types of mattresses compress, the space between the mattress and the bed rail may increase and pose additional risk of entrapment". It is noted in the HC guidance document that therapeutic air surfaces are technically exempt from the prescribed entrapment zone testing, for zone 2, 3 and 4, due to the highly compressible nature of these mattresses. It is noted that when these products are used, steps are to be taken to ensure that the therapeutic benefit outweighs the risk of entrapment.

On April 20, 2017, the SSM explained to the Inspector that he understood that there was to be an assessment process for all residents in the home, related to bed rail use. The SSM indicated that if it was determined that the bed rails were to stay in use for residents

#002, #003 and #004, he would need something to make them more secure, to prevent entrapment.

The current written plans of care for resident #002, #003 and #004's were reviewed by the Inspector on April 20, 2017. There was no reference to the use of bed rails for resident #002 and #004. For resident #003, it was noted that "bed rail used for repositioning". Resident #002 was noted to have a diagnosis related to cognitive impairment.

Resident #002 was observed for 10 minutes on April 20, 2017 while sleeping in bed on a therapeutic air surface with two quarter rails in use. The resident was still during the observation period. The observation period occurred in the resident's bedroom, while the Inspector spoke with Personal Support Worker (PSW) #S112, who indicated that as soon as the resident is put into bed, she/he falls asleep. The PSW explained that because of how resident #002 moves in bed, pillows are placed on either side of the resident when she/he is sleeping.

Resident #002 was observed for approximately 20 minutes on April 21, 2017 while in bed on a therapeutic air surface with two quarter rails in use. The left side of the resident's bed was against the wall and the bed was in its lowest position. There was a personal alarm clipped to resident #002's upper back area, and the monitor was on the mattress next to his/her pillow. Initially, the resident was awake and was moving his/her left arm, grabbing at the side wall. PSW #S119 explained to the Inspector that the resident moves himself/herself in bed in specified ways, which can result in the resident exiting the bed unattended. PSW#S119 showed the Inspector that there was a pillow at resident #002's right shoulder area, which she said was to prevent him/her from holding onto the bed rail. PSW #S119 and the resident's spouse, who was in the room at the time of observation, informed the Inspector that resident #002 will grab hold of the bed rail for strength to move himself/herself in a specified way, which can position the resident in a manner that allows the resident to exit the bed unattended. It was noted that at this point in the conversation that resident #002 was asleep and was still. The spouse elaborated as to how the resident moves in bed and how the resident is typically found when he/she has exited the bed unattended. The spouse indicated that he/she felt that the resident's ability to move himself/herself in bed in specified ways was unpredictable.

Resident #002's most recent fall was an identified date in April 2017. On April 21, 2017, the Inspector reviewed a fall management progress note that was made by Registered Nurse (RN) #S121, in relation to the most recent fall. The RN wrote, in part "…Cognitive

impairment. Bedrails is not appropriate to resident's condition..Continue to monitor resident q30 mins…"

Resident #002's progress notes were reviewed by the Inspector, for the period of January 1, 2017 to April 21, 2017. There were ten documented incidents whereby resident #002 had been found by nursing staff, in the resident's bedroom, having exited the bed unattended. A note made on an identified day in February 2017, by RN #S104, and a note made on an identified day in March 2017, by RN #S122, described that the resident was found with certain body parts in contact with the bed system and certain body parts not in contact with the bed system. A note made on a second identified day in March 2017, by RN #S120, described that the resident continued to actively move in bed and remained at high risk for exiting the bed unattended. A note made on a third identified day in March 2017, by RN #S117, and a note made on an identified day in April 2017, by RN #S104, described that the resident was found in close proximity to the bed, but was not in contact with the bed. RN #S104 noted that the resident tries to hold on to something to exit the bed unattended.

Resident #003 was observed on April 24, 2017 in bed on a therapeutic air surface with two quarter rails in use. The head of the bed was elevated. The resident indicated that the head of his/her bed was always raised as such. Resident #003 told the Inspector that he uses the bed rails to turn himself/herself and reposition, which he needs to do because of impaired skin integrity.

Resident #004 and the Inspector spoke on April 24, 2017 in the resident's bedroom. On the resident's bed there was a therapeutic air surface with two half rails (assist rails) in the down position, which is the position for this type of rail when they are in use. The resident confirmed that the bed rails are always in use when he/she is in bed. Resident #004 told the Inspector that he/she uses the bed rails to turn himself/herself and reposition.

In a meeting with the Administrator on April 21, 2017, the Inspector was informed that safety monitoring checks would be conducted for resident #002, #003 and #004 every 15 minutes, starting that evening. In order to accomplish this, private sitters would be brought in. The Administrator explained that this interim process would stay in place until it was determined what accessories could be used to modify the bed systems.

On April 24, 2017, the Director of Care (DOC) informed the Inspector that an interdisciplinary team had been created, to assess all residents with bed rails in use. The

DOC informed that the team would begin working on the assessment process that week.

The licensee failed to ensure that resident #001, #002, #003 and #004 were assessed in accordance with prevailing practices, with regards to bed rail use, to minimize risk to the resident. The non-compliance referenced above is issued as additional information in support of compliance order #001, served to the licensee as a result of Resident Quality Inspection # 2017_658178_0002, on April 7, 2017.

2. Related to the evaluation of residents' bed systems, with reference to resident #001:

On an identified date in April 2017, resident #001 was found by Personal Support Worker #S116 in his/her bedroom with certain body parts in contact with the bed system and certain body parts not in contact with the bed system. Registered nursing staff on the unit were alerted and attended the room. Upon further assessment, resident #001 was determined to have no vital signs and the on-call physician and coroner were notified of the unexpected death.

As per discussion with the Support Services Manager (SSM) over the course of the inspection, it was ascertained that in October 2014, all 242 resident's bed systems were evaluated. This was done by the SSM and an outside service provider. Since that time, the SSM explained that he had evaluated all new bed systems that have come into the home. The SSM speculated there had been approximately 80 new beds since October 2014. The SSM estimated that in addition to the new beds, he had re-evaluated approximately a quarter of the resident's bed systems since October 2014, as well as bed systems where there may have been a concern about resident entrapment.

With regards to entrapment zone 2 - On April 11, 2017, as requested and observed by the Inspector, the SSM tested entrapment zones 2, 3 and 4 on both bed rails on resident #001's bed system. For zone 2, the SSM initially tested the zone by inserting the cone, small end first, into the gap between the mattress and the lower edge of the rail, between the rail supports. Then, the SSM pushed down with observable effort, and as the cone did not go through the space, it was concluded that zone 2 passed. The HC guidance document was then reviewed, related to the prescribed testing process for zone 2. The HC guidance document directs that the cone is to be left to compress the mattress and should not be forced into the area. A spring scale is then to be attached to the loop on the end of the cone, and the tester is to pull on the spring scale with 12 lbs of force at any angle that increases the chance of the cone going through the space. The SSM repeated the test in the prescribed way, and zone 2 passed the test on resident #001's bed

system. The SSM acknowledged that while zone 2 had been tested in the prescribed way when all bed systems were evaluated in 2014, any testing that he had done since then had been done in the way he initially demonstrated.

With regards to a change of mattress - On April 13, 2017, the SSM informed the Inspector that when a new mattress was put onto a bed, there was no process in place to evaluate the resulting new bed system. The SSM indicated that he knew this would have to change. On April 21, 2017, the SSM clarified that when a new or previously used mattress was put onto a bed, the resulting new bed system had not been evaluated.

In relation to resident #001, the SSM explained that his/her bed system used to have a Zenith mattress. At some point, the SSM was made aware that resident #001 did not like the Zenith mattress. In response, the SSM found a different type of mattress for resident #001 to use. The SSM could not recall when the mattress was changed on resident #001's bed. The SSM confirmed that resident #001's bed system was evaluated with the Zenith mattress in place. The SSM confirmed that resident #001's bed system had not been evaluated since the mattress had been changed, until requested to do so by the Inspector on April 11th, 2017.

The licensee has failed to ensure that where bed rails are used, the resident's bed system is evaluated in accordance with evidence-based practices, to minimize risk to the resident, specifically related to entrapment zone 2 and to new bed systems resulting from a change of mattress. [s. 15. (1) (a)]

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 with the requirement that where bed rails are in use, the resident's bed system is evaluated in accordance with evidenced based practices, specifically with regards to the evaluation of new bed systems resulting from a change of mattress and the testing of entrapment zone 2, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

On an identified date in April 2017, resident #001 was found by Personal Support Worker #S116 in his/her bedroom with certain body parts in contact with the bed system and certain body parts not in contact with the bed system. Registered nursing staff on the unit were alerted and attended the room. Upon further assessment, resident #001 was determined to have no vital signs and the on-call physician and coroner were notified of the unexpected death.

As found in the Point Click Care (PCC) system, over the course of the inspection the Inspector reviewed the care plan in place at the time of resident #001's death, the associated Kardex and the most recent MDS assessment (March 24, 2017). As it was not accessible to the Inspector in the PCC system, the Director of Care (DOC) provided the Inspector with the MDS Kardex. In discussion with the DOC on April 21, 2017, she indicated her agreement that these sources of information could be taken to represent the plan of care for resident #001.

In the care plan focus section "high risk for fall r/t…", the first specified intervention directed that a chair alarm was to be placed on resident #001's wheelchair/Walker for his/her safety to notify staff when he/she attempts to get out/wander away from walker. Bed alarm chair alarm number". The second intervention was related to the resident's bed. The revision date for this focus section was January 3, 2017, by RN #S104. In the MDS Kardex, chair alarm and bed alarm were selected, with no details.

Over the course of the inspection, it was confirmed that a CareSense Personal Monitor was in use for resident #001 when he/she was in her wheelchair and also when he/she

was in bed. This was referenced as a chair alarm by the home's staff. Resident #001 did not use a walker, and as indicated in his/her care plan, the resident required total/extensive assistance to push his/her wheelchair on and off the unit. As well, it was determined that a Cordless Advanced LCD Bed and Chair Monitor was in use for resident #001, with a sensor pad, when the resident was in bed. This was referenced as a bed alarm by the home's staff.

On April 21st, 2017, the Inspector and the Director of Care reviewed resident #001's care plan. The DOC indicated that she did not know what the statement "bed alarm chair alarm number" meant, speculating it was pulled from the PCC library. The DOC noted that no information was provided about the use of the chair alarm for resident #001 when in bed.

On April 20th, 2017, the Inspector and the Administrator reviewed resident #001's care plan. The Administrator indicated that she did not understand why anyone would write "bed alarm chair alarm number". The Administrator speculated that the statement was pulled from the PCC library and indicated that it served no purpose. The Administrator agreed that the care plan did not give any information about the use of the chair alarm for resident #001 when in bed.

On April 20th, 2017, the Inspector and the Assistant Director of Care (ADOC) reviewed resident #001's care plan. The ADOC indicated that she did not understand what "bed alarm chair alarm number" meant as bed alarms and chair alarms do not have numbers. The ADOC acknowledged the care plan did not give any information about the use of the chair alarm for resident #001 when the resident was in bed.

The written plan of care for resident #001 did not set out the planned care for the resident, specifically with regards to the use of the chair alarm for the resident when in bed. [s. 6. (1)]

Issued on this 10th day of May, 2017

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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2017_625133_0008
Log No. / Registre no:	007372-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 9, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE LAURIER MANOR 1715 MONTREAL ROAD, GLOUCESTER, ON, K1J-6N4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Cummins

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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee is ordered to:

1. Provide formalized, documented education to staff involved in the use of personal alarms and bed alarms for residents in the home, as per the manufacturers' specifications. The education is to include demonstration of the correct and expected use and testing of the personal alarms and bed alarms (monitors and sensor pads). The education is to be specifically targeted to the level of use (i.e. nursing vs. maintenance).

2. Develop and implement a documented routine auditing process, to ensure that personal alarms and bed alarms are being used in accordance with manufacturers' specifications.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

On an identified date in April 2017, resident #001 was found by Personal Support Worker #S116 in his/her bedroom with certain body parts in contact with the bed system and certain body parts not in contact with the bed system. Registered nursing staff on the unit were alerted and attended the room. Upon further assessment, resident #001 was determined to have no vital signs and the on-call physician and coroner were notified of the unexpected death.

On April 11th, 2017, the home's Administrator informed the Inspector that there had been a chair alarm in use for resident #001 in bed (referenced as a personal

alarm) and that the cord was still attached to resident #001's clothing when he/she was found. As well, the Administrator informed the Inspector that there had been a bed alarm in use for resident #001.

The Inspector reviewed the manufacturer's instructions for what had been referenced as a chair alarm by the Administrator, the Curbell Medical CareSense Personal Monitor, as provided by the home's Support Services Manager (SSM). In the "Safety Information" section, the third warning was as follows "NEVER use if the monitor cannot be securely mounted to the wheelchair, headboard or door bracket". This device will be referenced below as a personal alarm or PA.

The Inspector reviewed the manufacturer's instructions for the bed alarm, the Curbell Medical Cordless Advanced Bed and Chair Monitor, as provided by the home's SSM. In the "Installing the Batteries" section, point #3 was as follows: always use new alkaline batteries and replace them all at the same time. Do not mix battery types/brands. As well, in the "Mounting the Monitor" section, there was the following warning: "NEVER use the monitor if it cannot be securely mounted". This device will be referenced below as a bed alarm or a BA.

Related to the placement of the personal alarm (PA) monitors when in use for a resident in bed, including resident #001:

On April 12th, 2017, in the presence of the Administrator, Registered Nurse (RN) #S104 explained to the Inspector that she had found the PA cord clipped to resident #001's back left upper shoulder area on the identified date of the resident's unexpected death. The RN confirmed that the clip had not detached from the PA monitor and that there was no alarm. The RN could not recall where the PA monitor was when she unclipped the cord from resident #001, but noted that it had moved with the resident. The RN indicated that sometimes the Personal Support Workers (PSWs) will place the PA monitors under a resident's pillow, but that it depends on the individual, and sometimes the PA monitor is placed next to the resident on the mattress up towards the headboard. The Administrator directed the RN to follow up with staff about placement of the PA monitors, as they should be placed on the headboard.

RN #S104 sought out the Inspector, at approximately 17:50 hours on April 12th, 2017, to inform that she had spoken with a group of PSWs about placement of the PA monitors. The RN explained that the PSWs had informed her that the clip on the back of the PA monitors is too tight and does not allow it to be secured to

a headboard. RN #S104 and the Inspector went to resident #001's bedroom, and the RN demonstrated that the PA monitor could not be clipped to the headboard.

On April 12th, 2017, PSW #S109 explained to the Inspector that in the past, PSWs attached the PA monitors to residents' bed rails with a Velcro strap. The PSW explained that as the Velcro straps went missing over the last few years, they were never replaced. The PSW explained that there was one resident (#005) on a specified unit that still had a Velcro strap attached to her/his PA monitor and that it was strapped to resident #005's bed rail when the resident was in bed. The PSW indicated that she will normally put the PA monitor under a resident's pillow, and when the resident moves, she finds that the PA cord normally detaches from the monitor. The PSW indicated she may also put the PA monitor between the headboard and the mattress.

On April 12th, 2017, PSW #S110 explained to the Inspector that she puts the PA monitor under a resident's pillow. The PSW indicated that when the resident moves, the cord does not disconnect. The PSW explained that the new beds have thicker headboards, and the clips on the back of the PA monitors do not fit the headboards. The PSW estimated that it had been about 3 years since they've had the new beds.

On April 13th, 2017, the Director of Care (DOC) showed the Inspector a new PA, still in its packaging. It was noted that a Velcro strap was included with the package. The DOC explained her understanding that only sometimes would a PA be used for a resident in bed, and that she would prefer that bed alarms be used for this purpose. The DOC indicated that if a PA was to be used for a resident in bed, the PA monitor would be attached to the bed with Velcro or with the clip on the back of the monitor. The DOC indicated that if staff put the monitor beside the resident in the bed, there would be no purpose to it, as the monitor needs to be attached to something.

On April 18th, 2017, the acting Assistant Director of Care (aADOC) explained to the inspector that her understanding was that for a few residents, PSWs would use the PA in the bed. The aDOC qualified that she understood that this would be done only for a short period, such as if there was something wrong with the resident's bed alarm. The aADOC explained that she used to work on the 3rd floor prior to steeping into her current role in December 2016. The aADOC indicated that when she was on 3rd, it was not supposed to be the practice that

PSWs would use a PA for a resident in bed, but she did see it happen. The aADOC said that she had observed that PSWs would put the PA monitor on the residents' mattress, above the pillow.

On April 18th, 2017, PSW #S112 explained to the Inspector that when she uses a PA for a resident in bed, the monitor goes under the pillow or near the pillow. The PSW indicated that it had always been like that, as the PA monitor clips are too tight to fit onto the bedframes.

On April 18th, 2017, PSW #S113 confirmed to the Inspector that she had put resident #001 to bed after his/her last meal on the identified date of the resident's unexpected death. PSW #S113 explained that she had attached the PA cord to resident #001's upper back shoulder area, and the monitor was in the bed, close to the pillow.

On April 19th, 2017, PSW #S115 confirmed to the Inspector that after resident #001 was initially found, by another PSW, she was one of the first to see the resident on the date of the resident's unexpected death. PSW #S115 confirmed that the PA cord was still attached to resident #001 and the PA monitor was in the bed. PSW #S115 said she could understand that the PA did not go off because the monitor had moved along with the resident.

On April 19th, 2017, PSW #S116 confirmed to the Inspector that she had found resident #001 on the identified date of the resident's unexpected death. PSW #S116 explained that she had noticed that resident #001's PA was clipped to him/her, the monitor was in the bed, and everything was intact.

On April 20th, 2017, Registered Nurse (RN) #S117 indicated to the Inspector that when a PA is in use for a resident in bed, most of the time she sees the monitor under the pillow to hide it so the resident cannot see it.

On April 20th, 2017, the Extendicare Regional Director with responsibility for the home indicated that the PA that was in use for resident #001 had served no purpose because the monitor was not secured to anything. He indicated that he thought it may be best not to use the PAs for residents in bed.

On April 20th, 2017, the Assistant Director of Care (ADOC) informed the Inspector that she had been in her position since September 2015. Prior to that, she had been worked as the RN on 2nd, 3rd and 5th floors. The ADOC

explained that when she was on the floors, PAs would follow a resident from their wheelchair to their bed, and the PA monitors would be put under the residents' pillow. The ADOC indicated that she does not see any PA monitors with Velcro now, noting that the PAs that used to be in use in the home were smaller, a little rectangle, and they all had very thick Velcro on them. The ADOC noted the PAs in use now are very heavy, and since they have been in use, PSWs have been tucking them somewhere into the bed as they do not have the Velcro like they used to. The ADOC indicated that she had never raised this issue as a concern to the Director of Care because she never understood that it was a problem. The ADOC indicated that she now understood that putting the PA monitors in the bed with the residents does not make sense. The ADOC informed that they would be moving away from using the PAs for residents in bed, once all residents who required it were provided with a bed alarm.

On April 20, 2017, the Director of Care (DOC) confirmed to the Inspector that a decision had been made to stop using PAs for residents in bed. The DOC informed that a list of all residents with PAs or bed alarms (BAs) in use had been compiled, and that all BA monitors had been affixed with Velcro to the residents' bed footboards. The DOC explained that more BAs would be ordered, with bed mounting brackets, so that residents who only had a PA could also be provided with a BA if it was needed for them in bed. As per the list compiled, there was approximately 50 residents in the home with a PA. Resident #002 was identified as one of the residents for which a BA was being ordered.

The Inspector observed resident #002 in her/his bed while awake and while sleeping, on April 21, 2017. There was a PA cord attached to the resident's upper back shoulder area and the monitor was on the mattress next to the pillow. Progress notes were reviewed for resident #002, for the period of January 1, 2017 to April 21, 2017. There was 12 documented occasions where resident #002 had been found by nursing staff to have exited the bed unattended. Twice the resident was found with certain body parts in contact with the bed system and certain body parts not in contact with the bed system.

On April 21, 2017, the DOC informed the Inspector that 40 BAs had been ordered. The DOC indicated that since her and the Inspector had first discussed this issue, she had realized that she had seen PAs being used in bed for residents but had not thought much about it. The DOC indicated that she now understood that the way the PAs were being used for residents in bed was not serving a purpose.

Related to resident #001's bed alarm (BA) monitor and batteries:

On April 12th, 2017, maintenance worker #S107 unscrewed and removed the battery cover on the bed alarm monitor that had been in use for resident #001. It was observed that there were two different sets of batteries, two orange Duracell Procell batteries and two black and silver Energizer Industrial batteries. The maintenance worker stated that all batteries are supposed to be replaced at the same time, and that the same type and brand of batteries are to be used. The maintenance worker indicated that the orange Duracell batteries are used by the maintenance department, while the black and silver Energizer batteries are used by the nursing department.

On April 20th, 2017, in discussion with the Administrator, Director of Care and Assistant Director of Care, it was confirmed that the nursing department uses the same orange Duracell Procell batteries that are used by the maintenance department. It was noted however that the black and silver Energizer Industrial batteries are ordered for use with IV pumps.

On April 21, 2017, RN #S104 showed the Inspector a box of black and silver Energizer Industrial batteries, for use with IV pumps, in the 3rd floor nurses' station "dressing for East side" upper cupboard.

Related to the placement of bed alarm (BA) monitors:

On April 13th, 2017, PSW #S111 explained to the Inspector that she had given resident #001 a snack, after the resident's last meal, on the identified date of the resident's unexpected death. The PSW told the Inspector that she remembered seeing the BA monitor on the bed side table.

On April 18th, 2017, PSW #S112 told the Inspector that when she uses a BA for a resident, the monitor is always placed on the bed side table.

On April 19th, 2017, PSW #S115 confirmed to the Inspector that when a BA is in use for a resident, the monitor is on the bed side table.

On April 19th, 2017, PSW #S116 confirmed that when a BA is in use for a resident, the monitor is on the bed side table.

On April 20th, 2017, maintenance worker #S107 explained to the Inspector that the BAs currently in use in the home have been in use for many years and that the monitors have always been placed on the bed side tables. Maintenance worker #S107 explained that once he has programed a BA monitors to an alarm pad, they are brought to the nurses' station and it is nursing staff that put them into place.

On April 20th, 2017, the Administrator informed the Inspector that there had been discussion with the management team in recent morning reports, following the death of resident #001, regarding the need for PA monitors and BA monitors to be securely mounted. The Administrator noted that having the PA monitor in the bed with a resident serves no purpose and indicated that she had never seen this done before. The Administrator noted that if a resident was sliding down the bed trying to get up or scooting down the bed trying to get out, the PA monitor will just move with the resident and not activate. Later that day, the Director of Care reported to the Inspector that all BA monitors had been attached to the foot of the residents' beds with Velcro.

The licensee has failed to ensure that staff use the Curbell Medical CareSense Personal Monitor in accordance with manufacturers' instructions, specifically related to the placement of the monitors when they are in use for a resident in bed.

The licensee has failed to ensure that staff use Curbell Medical Cordless Advanced Bed and Chair Monitors in accordance with manufacturers' instructions, specifically related to the placement of the monitors, and, with regards to resident #001's monitor, related to the use of battery types.

The scope of the non-compliance described above is widespread as it applies to all residents with a personal alarm monitor in use when in bed and all bed alarm monitors. The non-compliance presents potential risk of harm to the residents. A compliance order will be issued. [s. 23.] (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

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. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee is ordered to:

1. Develop and implement a written procedure to ensure that resident bed systems are maintained at a level that meets manufacturer specifications, at a minimum. The bed system maintenance procedure shall include reference to manufacturer specifications for all bed systems in use in the home. The date(s) on which the specified maintenance is performed is to be documented.

2. Ensure that all beds systems in the home have been maintained in accordance with the written procedure.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that residents' bed systems are maintained at a level that meets manufacturer specifications.

On April 20th, 2017, the SSM informed the Inspector that he had completed entrapment zone testing for all bed systems with half rails on them, also known as assist rails, with the rails in the “up” position. The SSM had previously informed the Inspector, on April 11, 2017, that these bed rails had only been tested in the “down” position. The SSM noted that he had found that some of the bed rails needed to be tightened. He qualified that the bed rails had passed the initial entrapment zone testing, but there was some play when he jiggled them, and he wanted them all to be as tight as possible. The SSM referenced two residents’ bed rails that had required a change of hardware, which was done by maintenance staff, as the SSMs initial tightening of the hardware did not solve the problem. As discussed and as per the worksheet that the SSM had made notes on while testing the bed rails, titled “Half Assist Rails”, of the 50 residents’ beds that were tested, 13 required tightening of one or both bed rails. As discussed and as per the worksheet, 34 of the 50 residents’ beds that were checked were CS series beds. The SSM confirmed that these beds were the majority in the home. As per the SSM’s bed entrapment worksheet, on which the results for all entrapment zone testing for all residents’ beds was documented, 203 of 242 beds in the home were CS series beds.

As per the Invacare CS Series Beds CS3, CS5, CS7, CS9FX600 User Manual, annual maintenance checks are prescribed. Required checks include, but are not limited to, the following: Inspect rail latches. Ensure that all rails engage and lock as specified; Inspect rails for wear and damage and replace as required.;

Lubricate rail pivot points as needed.; Tighten, adjust or replace any parts or bolts etc. that are loose or show signs of wear. As well, a warning in the Annual Maintenance Check section indicates "When evaluating the condition of rail attachments it is necessary to consider all aspects of the bed-rail system, including consideration of the rails, mattress, and bed system. Refer to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment published by the U.S. Department of Health and Human Services Food and Drug Administration."

The Inspector reviewed the "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" document referenced in the CS series user manual and found that it mirrored the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". These documents characterize, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4). On August 21, 2012, a notice was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, directing that the Health Canada guidance document was to be used as a best practices document.

Over the course of the inspection, the SSM confirmed that there had not been an annual process in place to evaluate bed systems with regards to bed rails and the potential entrapment zones. The SSM had indicated that all 242 residents' bed systems were evaluated in October 2014. Since that time, the SSM approximated that 80 new beds had come into the home and he confirmed that they had been evaluated. The SSM indicated that in addition to the new beds, he had re-evaluated approximately a quarter of the residents' bed systems since October 2014. As well, the SSM indicated that he had evaluated bed systems where there may have been a concern about resident entrapment. As a result of the SSM's record keeping method with regards to bed system evaluation, it could not be determined when a bed system had last been evaluated.

On April 24, 2017, the SSM confirmed to the Inspector that there had not been a preventative maintenance program in place for residents' beds. It was

confirmed that staff were expected to report any problems they became aware of in relation to a resident's bed. Manufacturer specifications for annual maintenance checks for the CS series beds were discussed. The SSM informed that an annual bed system evaluation process would be implemented that would encompass manufacturer specifications, including entrapment zone testing and all specified maintenance checks.

On May 2, 2017, the Administrator confirmed to the Inspector that the licensee did not have a procedure developed to ensure that resident bed systems are maintained at a level that meets manufacturer specifications.

The licensee has failed to ensure that procedures are developed to ensure that resident bed systems are maintained at a level that meets manufacturer specifications, at a minimum.

The scope of the non-compliance described above is widespread as it applies to all residents' beds in the home. The non-compliance presents potential risk of harm to the residents. A compliance order will be issued. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 08, 2017

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 soins 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 soins 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 9th day of May, 2017

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : JESSICA LAPENSEE

Service Area Office /
Bureau régional de services : Ottawa Service Area Office