Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 30, 2017;	2017_574586_0009 (A1)	008281-17	Resident Quality Inspection

Licensee/Titulaire de permis

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

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

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

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

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JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension on compliance date as requested by the home.

Issued on this 30 day of May 2017 (A1)

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

Original report signed by the inspector.

Ontario

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

JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 26, 27, 28, May 2, 3, 4 and 5, 2017.

The following Follow-up Inspection was completed concurrently with the RQI:

008281-17 - Plan of Care

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Maintenance Supervisor, Maintenance Assistants, Dietary Manager, Program Supervisor, Clinical Coordinator, Staff Development Coordinator, Physiotherapy Assistant (PTA), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), families and residents.

During the course of the inspection, the inspector(s) toured the home, reviewed resident health records, medication incident investigation notes, audits, policy and procedures, Risk Management Reports, and training records, interviewed staff and observed resident care and dining. Note that an inspector-in-training was on-site during the RQI.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

- **15 WN(s)**
- **5 VPC(s)**
- **2 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On an identified date, resident #041 eloped from the home. After the incident, the documented plan of care was updated for staff to keep the resident on a particular home area to reduce the risk of that happening again.

During the inspection, RPN #105 informed the LTC Inspector that staff were directed to bring the resident to the particular home area and they must remain there until they are put to bed. They indicated that the resident preferred to lie down or nap between their meals, and that they were often sore or uncomfortable

as they did not have their room or bed to sleep in, requiring them to wander the unit or sit in a chair all day.

The LTC Inspector spoke with the resident's substitute-decision maker (SDM), who indicated that the resident had been voicing their concern about having to spend their days on that unit, saying that specific reasons why they were unhappy there. The resident's SDM also acknowledged that the resident preferred to lie down during the day and was in pain when they had to sit or stand all day. During this interview, the resident said they were uncomfortable from standing.

During interview with the DOC, they acknowledged that the resident was not comfortable and should have access to their room and bed throughout the day as they please. They acknowledged that the current plan of care did not meet the needs and preferences of resident #041. [s. 6. (2)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A. During the course of this inspection, resident #002 was observed with a particular falls prevention intervention. Review of the documented plan of care identified the resident required this. Review of three subsequent Minimum Data Set (MDS) assessments indicated that the resident did not use this type of device. Interview with the Staff Development Coordinator stated the resident did have the device and confirmed that the MDS assessment and the Restraint Assessment were not consistent with each other.

B. On three days during the RQI, resident #030 was observed with a particular falls prevention intervention. Review of the documented plan of care identified they required the a specific device as a restraint for safety. Review of the MDS assessment completed in February 2017, identified that they did not use this device. Interview with the Staff Development Coordinator confirmed the resident did require the device and the MDS assessment and the Restraint Assessment were not consistent with each other.

C. During the course of this inspection, resident #011 was observed with a particular falls prevention intervention. Review of the Restraint Assessment indicated they required a restraint for safety.

Review of the MDS assessment revealed the resident was not assessed as using this device. Interview with Staff Development Coordinator confirmed they did have this device and the MDS assessment and the Restraint Assessment were not consistent with each other.

D. On two dates during the RQI, resident #011 was observed in bed with bed rails raised. Review of MDS assessment indicated that bed rails were not used and review of the Restraint Assessment identified that the resident required the bed rails raised when in bed as a PASD. Interview with Clinical Coordinator stated the resident did require the bed rails raised when in bed and confirmed that the MDS assessment and the Restraint Assessment were not consistent with each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) On an identified date during the inspection, resident #002 was observed seated in their specific type of wheelchair with a falls prevention intervention attached to the wheelchair but was not applied to the resident. Review of the plan of care identified they were at risk of falls and required that specific interventions. Interview with RPN #117 stated the device was supposed to be attached to the resident at all times and confirmed that care was not provided to the resident as specified in the plan.

B) Resident #042 was identified as a risk for falls and had interventions in place to minimize the risk for falls. As per the plan of care, a specific intervention was to be applied when the resident was in bed to prevent injury.

On an identified date during the inspection, it was observed that there was no falls prevention device in resident #042's room.

The following day, the resident was observed by inspector #683 at 0740 hours sitting at the end of their bed in their pajamas, while a PSW entered into the room to assist them out of bed and provide morning care. There was no falls prevention device in place or in the room.

Interview with PSW #120 confirmed that the resident was to have this device in place and it was usually stored in their bedroom. PSW #120 and RPN #111 were unable to locate it on the unit.

It was confirmed by staff #111 that the resident's falls prevention device was not used as specified in the resident's plan of care.

C) Resident #043 was identified as having a risk for falls and had interventions in place to minimize the risk for falls. As per the plan of care, the resident was to have a specific falls prevention device in good working condition, correctly positioned on them. The plan of care noted that the resident was capable of removing it, and staff were directed to "please monitor."

On an identified date during the inspection, the resident was observed by inspector #581 sitting in their wheelchair visiting with family, and their device was not applied.

Interview with RPN #117 acknowledged that this was not attached as specified in the resident's plan of care. They indicated that it should have been applied but staff may not have done so after toileting. Resident #043 was not provided the care set out in their plan of care. [s. 6. (7)]

4. The licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

On two dates during the RQI, resident #002 was observed with a particular oral status. Review of the plan of care identified that they had identified a different type of oral status. Interviews with PSW #115 and RPN #117 revealed different responses to the resident's current oral status. RPN #117 confirmed the plan of care was not reviewed and revised when their care needs changed related to oral care. [s. 6. (10) (b)]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and were consistent with and complement each other, to be implemented voluntarily.

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices included a document endorsed by Health Canada titled

"Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Food and Drug Administration, which outlined that decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized patient assessment using an interdisciplinary team with input from the patient and family or the patient's legal guardian. Furthermore, the document detailed guidelines for bed system evaluation and testing for potential zones of entrapment.

A. On two dates during the inspection, resident #002 was observed in bed with one bed rail raised in the guard position and one raised in the transfer position. Interview with PSW #115 stated the resident required the bed rails raised when in bed to assist with turning and repositioning. Review of the documented plan of care identified the bed rails were to be raised when in bed. Interview with RPN #117 stated that the resident only had one rail raised and did not consider the bed rail raised in the transfer position as being used. RPN #117 confirmed the resident required the bed rails for bed mobility and that a bed risk assessment was not completed for the use of the bed rails.

B. On two dates during the inspection, resident #004's bed was observed with bed rails raised. Interview with PSW #118 stated that the bed rails were raised when in bed for turning and repositioning. Review of the MDS assessment completed in March 2017, confirmed the use of the rails. Interview with RN #111 confirmed the resident required the bed rails raised when in bed and that a bed rail risk assessment was not completed for the use of the bed rails.

C. On two dates during the inspection, resident #011 was observed in bed with bed rails raised. Review of the Restraint Assessment completed in 2017 identified they required the rails as a restraint; however, the Restraint Assessment completed identified they required the rails as a PASD. Interview with RN #110 stated the night registered staff stated the resident did not require the bed rails raised as a restraint but now required them as a PASD. Review of the physician order directed staff to discharge the bed rails as a restraint and directed staff to apply bed rails for an alternative reason. Interview with RN #110 stated the resident required the bed rails as a PASD and confirmed that a bed rail risk assessment was not completed when the resident used the bed rails as a restraint nor was one completed when resident #011 required the bed rails as a PASD.

Interview with the Staff Development Coordinator confirmed that no bed rail

assessments had been completed in the home to minimize the risk to residents. [s. 15. (1) (a)]

2. The licensee failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On two dates in 2017, resident #011 was observed in bed with bed rails raised. Review of the plan of care identified they required the rails. Review of homes bed entrapment test, dated indicated that the bed system failed zone two. Interview with the Maintenance Assistant stated that entrapment zones were assessed but failed zone two even after the home applied an intervention to the bed rail to mitigate the risk to the resident.

Review of the document that identified the beds tested for zones of entrapment with the Maintenance Assistant confirmed that 40 beds in the home failed zone two and there was no plan in place to mitigate this risk after it was identified. Interview with the Administrator on May 3, 2017, stated they were unaware that 40 bed failed zone two and identified that this was a high risk to residents' safety when in bed with the bed rails raised.

The Bed Entrapment Test document that was completed in 2017 also identified that 18 beds had a cap rail missing. The Maintenance Assistant showed the LTC Inspector one, three quarter and one assist bed rail with the cap rail missing and the surface was rough and sharp. They confirmed that the surface had the potential of scraping or causing harm to the resident's skin if they came in contact with the open surface. After consulting with the Maintenance Manager, a plan was implemented to cover the open rail cap with gorilla tape to mitigate the risk to residents.

During this inspection the Administrator provided written documentation on May 4, 2017, that 22 beds received an accessory that reduced any entrapment risks that were identified and stated a bed rail risk assessment was completed on 18 residents which indicated they did not require bed rails raised on the beds. Administrator stated that those beds would receive an accessory to reduce any entrapment risks moving forward and the bed system would be retested to ensure that all zones of entrapment pass.

The home failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment for 40 residents. [s. 15.

(1) (b)]

Additional Required Actions:

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

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that restraining of a resident by a physical device under section 31 or 36 of the Act, was applied by staff in accordance with any manufacturer's instructions.

A. During the inspection, resident #002 was observed with a particular restraint in place, applied incorrectly. Review of the documented plan of care identified they required the restraint. Interview and observation of the restraint with RPN #109 confirmed that the belt was not applied correctly, according to the manufacturer's instructions and the staff member adjusted it.

B. During the inspection, resident #030 was observed with a particular restraint in place, applied incorrectly. Review of the Restraint Assessment identified they required the restraint and were unable to undo release themselves from it.

Interview with RN #110 stated the resident required the restraint and confirmed that it was not applied correctly, according to the manufacturer's instructions. The registered staff adjusted the restraint. The restraint was not applied in accordance with manufacturer's instructions. [s. 110. (1) 1.]

2. The licensee failed to ensure that where a resident was being restrained by a physical device under section 31 of the Act: that the resident was released from the physical device and repositioned at least once every two hours.

A. During the inspection, resident #002 was observed seated in a particular type of wheelchair with a restraint applied from 1040 hours to 1340 hours and they were not released from the restraint or repositioned. Review of the documented plan of care identified that the resident required the restraint. Interview with PSW #115 stated the resident was positioned in the particular type of chair with the restraint applied and confirmed the resident was not released or repositioned every two hours. Interview with RPN #117 stated that the restraint was applied and the PSW staff were to reposition and release the restraint every two hours or as needed.

B. During the inspection, resident #011 was observed in their wheelchair from 1045 hours to 1320 hours; they were not repositioned and their restraint was not released. Interview with PSW #116 stated the resident did use a restraint and confirmed they did not release the restraint from 0800 to 1320 hours and did not reposition them between 1000 to 1220 hours as they were sleeping. Interview with registered staff stated the resident was to be repositioned every two hours and the restraint released.

On another date during the inspection, resident #011 was observed with the restraint in place. Resident was observed from 0820 hours to 1320 hours and was repositioned by two PSW staff at 1000 hours but was not repositioned again and the restraint was not released during the above time period. Interview with PSW #116 stated the resident was repositioned at 1000 hours but the restraint was not released and confirmed they did not reposition or release the restraint at least once every two hours. [s. 110. (2) 4.]

3. The licensee failed to ensure that every use of a physical device to restrain a resident under s. 31 of the Act was documented, and without limiting the generality of this requirement, the documentation included all assessment, reassessment and monitoring, including the resident's response.

A. Resident #011's documented plan of care included the use of a particular restraint, as confirmed by RN #110. The home's policy, "Resident Safety – Revised Restraint Policy" (document number 08-01-28, last revised March 2017) directed staff to release, reposition and reapply the physical restraint every hour. The Staff Development Coordinator confirmed that staff were to document this in Point of Care (POC) under 'Restraint Use'.

The 'Restraint Use' documentation for resident #011 was reviewed and identified that the restraint was not released or reapplied every hour.

The home did not ensure that the monitoring of resident #011's physical restraint was documented.

B. During the course of this inspection resident #002 was observed with a restraint applied. Review of the documented plan of care identified they required the restraint and this was confirmed by RPN #117.

The 'Restraint Use' documentation on Point of Care for resident #002 was reviewed and identified that the restraint was not released or reapplied every hour.

Review of the Point of Care documentation with the Staff Development Coordinator revealed that there was no place for the PSW staff to document that they had released the physical restraint. They confirmed that the staff were to release, reposition and reapply the physical restraint every hour and that the documentation in POC was not completed for resident #002 and #011. [s. 110. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where a resident is being restrained by a physical device under section 31 of the Act: that the resident is released from the physical device and repositioned at least once every two hours, and to ensure that restraining of a resident by a physical device under section 31 or 36 of the Act, is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD used under section 33 of the Act, was applied by staff in accordance with any manufacturer's instructions.

During the inspection, resident #032 was observed with a particular falls intervention in place, applied incorrectly. Observation and interview with RN #110 stated that the device was incorrectly applied, not according to manufacturer's instructions. The device was not applied in accordance with manufacturer's instructions. [s. 111. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD used under section 33 of the Act, is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

On an identified date, the physician prescribed resident #071 to receive a particular medication for one week and then reassess. The medication order was processed and recorded on the electronic Medication Administration Record (eMAR). The noon medication pass was observed and the resident was administered the medication, as recorded on the eMAR. A review of the clinical record, including physician orders and progress notes, did not identify the medication was reassessed or reordered since the time of the order. On request RPN #123 reviewed the current medication orders compared to the eMAR directions and verified that the medication, although on the eMAR, should not have been administered, according to the order as it was not reassessed to continue by the physician. The medication was not administered in accordance with the directions for use by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and was reported to the resident, the resident's SDM, if any, the DON, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A. On an identified date during the inspection, during a noon medication pass resident #071 was observed to receive a specific medication, as recorded on the electronic Medication Administration Record (eMAR), by RPN #123.

Following a review of the clinical record it was identified that the resident no longer had an order for the use of the medication, which was confirmed by RPN #123 and the Clinical Coordinator . Following the confirmation with the RPN, the clinical record identified that the physician discontinued the use of the medication the same day; however, there was no additional documentation included in the progress notes related to the medication at the time that the physician discontinued the use of it.

Interview with RPN #123 and the Clinical Coordinator with Inspector #123 identified that no incident report was completed related to any medication incidents for resident #071. Interview with the Clinical Coordinator verified that the administration of the medication was an error and that an incident report should have been completed and all appropriate individuals should been notified of the error; however, these actions had not been completed.

B. A request was made to the DOC to provide reports of all medication incidents and adverse drug reactions for the past three months. Three incident reports were provided from December 2016, until March 2017, and the DOC and Clinical Coordinator each verified that these were the only medication errors reported during the identified time period. On review of the reports it was noted that each of the errors involved controlled substances.

Interviews with the DOC and the Clinical Coordinator verified that registered nursing staff had been instructed on multiple occasions to report all medication

incidents for follow up action, not just those which involved controlled substances. Interviews with RPN #123, RN #125 and RN #109 each verified the expectation that all medication incidents be reported. A review of the incident reports and progress notes for residents #011 and #070 did not include that the resident, the resident's SDM, if any, the DOC, the Medical Director, the prescriber of the drug, the attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider were notified of the incidents, which was confirmed with the DOC.

Not all medication incidents were documented, nor was there a record of actions taken to assess and maintain the resident's health, nor were the incidents reported to the resident, the resident's SDM, if any, the DON, the Medical Director, the physician and the pharmacy service provider. [s. 135. (1)]

2. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review, that any changes and improvements identified in the review were implemented, and that a written record was kept of everything provided for as outlined above.

The DOC identified that the home held quarterly Medication Meetings with the nursing management staff, at least two registered nursing staff members and the pharmacy. During this quarterly meeting the practice was identified that a "general" discussion was held regarding medication incident and adverse drug reactions and a discussion of trends only not each and every incident. It was communicated by the DOC that when a medication incident was identified the management staff addressed the specific issue(s) with the specific staff involved, at the time of the incident, and the incidents were only at the Medication Meetings, if the issue(s) were a trend or process concern.

The DOC provided the final copy of Meeting Minutes for the Medication Meeting held December 28, 2016, and the draft notes for the April 5, 2017, Meeting Minutes. The DOC referred to the December 28, 2016, minutes and identified that their quarterly review of the medication incidents for the quarter and documentation related to changes and improvements identified in the review were recorded as agenda item "Medication in pouch and vial" with discussion notes to include "staff needs to pay close attention to what they are giving" with an identified responsibility of "all staff".

The licensee did not ensure that there was a quarterly review of all medication incidents and adverse drug reactions and that any changes and improvements identified in the review were implemented nor a written record was maintained as required. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident which involves a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and is reported to the resident, the resident's substitute decision-maker (SDM), if any, the DON, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

During the initial tour of the home it was noted that the resident-staff communication system was not available in an identified dining room, and this was confirmed by the Maintenance Manager and the DOC. [s. 17. (1) (e)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (2) The policy must comply with such requirements as may be provided for in the regulations. 2007, c. 8, s. 29 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's minimizing of restraining policy complied with such requirements as may be provided for in the regulations.

According to O. Reg 79/10, s. 110 (2) 4., a resident being restrained by a physical device must be released from the physical device and repositioned at least once every two hours.

The home's policy, "Resident Safety – Revised Restraint Policy" (document number 08-01-28, last revised March 2017), staff were to release, reposition and reapply a physical restraint every hour, when a resident was awake, or more often, according to the needs of the individual resident, and if the resident was asleep, minimum interventions included, but was not limited to, hourly checks by a member of the nursing and personal care staff, to monitor the resident's comfort, safety and well-being, and the position of the restraint.

During the inspection, resident #011 was observed sleeping in their wheelchair. Interview with PSW #116 stated the resident did have a particular restraint applied and confirmed they did not release the resident from the restraint from 0800 to 1320 hours and did not reposition them between 1000 to 1220 hours as they were sleeping.

The home's policy directed staff to only reposition those residents who were restrained while awake, but not those who were asleep. As per the policy, those asleep only needed to be monitored hourly.

The home's minimizing of restraining policy did not comply with requirements provided for in the regulations. [s. 29. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk.

The home's policy, "Resident Safety/Emergency Procedures – Guidelines for Restraint Use" (document number 08-01-28A, last revised March 2017), under the Documenting Restraint Use heading, indicated that the Restraint Assessment and progress notes in Point Click Care (PCC) were to include a summary of the restraint order, the reason for the restraint, as well as alternatives that had been found to be effective at times.

During the course of the inspection, resident #011 was observed with a particular restraint in place. Interview with RN #110 confirmed that the resident used the physical restraint. Review of the plan of care included a Restraint Assessment; however, the assessment was incomplete and the section "Restraint Alternatives (indicate those considered and determine effectiveness) was left blank. RN #110 confirmed the assessment for the use of the restraint was not completed and alternatives were not tried. [s. 31. (2) 2.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

During Stage I of the inspection, RPN #105 identified to the LTC Inspectors that PSW staff were only allotted six gloves per shift. Interviews were completed with PSW's (#116, #102, #115 and #126) who confirmed that staff were allotted a certain number of gloves per month, and if they required more, they were to ask the registered staff. RPN #101 confirmed that they would retrieve additional gloves for PSW's if they required them, from the locked storage room on the third floor that only registered staff could access.

The PSW's each indicated that extra gloves were locked in a closet on the floor and were obtainable through the RPN. The staff stated that, although they could obtain extra products, it often took a 'long' time to get them as the RPN's were often busy in other home areas on the floor, and that the products were not available and accessible at the time they needed them. Often, the registered staff would not have enough gloves in stock on the unit, so the wait would be even longer. This would result in residents having to wait to receive care until gloves were brought to the unit. PSW's #102 and #115 indicated that they purchase gloves themselves and bring them in as 'back-up', and that most other staff do so as well.

The home did not ensure that supplies were readily available to meet the nursing and personal care needs of residents. [s. 44.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

Resident #003 was interviewed and reported that their family member purchased their incontinence product and that it was not supplied by the home.

The record of resident #003 was reviewed and the MDS assessment indicated that the resident was incontinent. The resident's documented plan of care was reviewed and it was noted that the resident was incontinent. It stated that the resident wore TENA product and the staff were to see the product list.

The product list was checked and it had no information related to the type of product the resident used. PSW #102 was interviewed and reported that the resident's family member supplied the resident's incontinence product. The home did not provide the product for the resident.

The DOC was interviewed and reported that the home was unaware that the family was providing an incontinence product for this resident and that the resident required incontinence product for comfort.

The Resident Profile Worksheet -Tena List was reviewed with registered staff #121 and PSW #128. They confirmed that there was no indication on the Tena list that the resident required any product and that the home did not provide an incontinence product for resident #003. They confirmed that according to the assessment of resident #003, they were incontinent; required an incontinent product and the documented plan of care indicated that staff should refer to the product list for required product.

The home failed to ensure that the resident #003's individualized plan of care to promote and manage continence was based on the assessment, and that the plan was implemented. [s. 51. (2) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure there were appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat.

During the inspection, residents #040 and #003 were eating their meals at tables that were observed to be slanted, which was impacting the resident's ability to eat their meal. PSW #102 and RPN #101 acknowledged that they have been aware of the damaged tables for approximately one week. The home did not ensure that the furnishings and equipment in resident dining areas were appropriate for each resident to meet their needs. [s. 73. (1) 11.]

WN #13: 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,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, and assistive aids and positioning aids in the home were kept in a good state of repair.

During the inspection, residents #040 and #003 were eating their meals at tables that were observed to be slanted, which was impacting the resident's ability to eat their meal.

PSW #102 confirmed that the home's process for contacting the maintenance department about any concerns on the home area was to alert the registered staff on the unit who then would contact maintenance through the maintenance log book. The Maintenance Supervisor also confirmed this, indicating that the home's expectation was for staff to fill out the Maintenance Communication and Request Log, and they encourage staff to do so; however, most times staff would not do so, rather would page the maintenance department if they knew they were in the building.

PSW #102 and RPN #101 acknowledged that these damaged tables were identified approximately one week ago. The RPN said that they had alerted maintenance staff about this a few days ago. A review of the Magnolia Maintenance Communication and Request Log did not identify this issue. The RPN was interviewed again and said they had only verbally alerted maintenance staff about this.

The Maintenance Supervisor was interviewed about the damaged tables and they indicated that they were not aware of the issue. The Supervisor spoke with their two Maintenance Assistants who also indicated that they had not been alerted about the damaged tables.

The home's procedure for non-routine maintenance was not implemented by staff. [s. 90. (2) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.

Review of the documentation the home provided identified that the home did not complete a monthly analysis of the restraining of residents by use of a physical device. Interview with Clinical Coordinator confirmed the home completed the analysis quarterly and not monthly. [s. 113. (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

During the inspection, lunch meal service was observed in a particular dining room. On two occasions resident #003 was observed dropping cutlery on the floor. During one of these instances, RPN #101 watched as resident #003 dropped their utensil on the floor, then picked it up and began to use it to eat. The home's policy, "Infection Control – Meal Service" (policy number 07-01-21, last revised June 23, 2016) directed staff to return any eating utensils to the dish machine for rewashing if they fall on the floor, and policy, "Dish & Cutlery Handling and Storage" (policy number 07-01-31, last revised June 23, 2016) directed staff to wash any dishes or cutlery that have fallen on the floor. Interview with the Dietary Manager confirmed that the staff should have discarded the cutlery that fell on the floor and provided the resident with new ones. The home's infection prevention and control program was not implemented. [s. 229. (4)]

Issued on this 30 day of May 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JESSICA PALADINO (586) - (A1)

Inspection No. / No de l'inspection : 2017_574586_0009 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 008281-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 30, 2017;(A1)

Licensee / Titulaire de permis : HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

LTC Home / Foyer de SLD : HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Rosemary Okimi

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To HERITAGE GREEN NURSING HOME, 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: 2017_570528_0005, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care for all residents, including but not limited to, residents #002, #042 and #043, is provided to the resident as specified in the plan, related to fall prevention interventions and strategies to mitigate risks to residents.

The licensee shall review this order report, along with the previous order report (2017_570528_0005) which identified similar non-compliance, with all front line staff and discuss the findings. They shall provide education regarding the plan of care and expectations of staff to ensure that the plan of care is provided to the resident.

The licensee shall also conduct and document auditing activities, at regular intervals, and on all shift, to ensure that fall prevention intervention and strategies to mitigate the risk to residents are provided to residents as specified in their plan of care. Specifically, ensuring chair and bed alarms and falls mats are in place for residents that require the use of these interventions.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the potential for harm/risk toward residents #002, #042 and #043, the scope of "isolated", and the Licensee's history of non-compliance (CO) on the February 21, 2017 Follow Up Inspection Report, Director's Review (DR) on the March 14, 2016, RQI Report, CO on the March 11, 2015 Complaint Inspection Report, and CO on the November 6, 2014 Complaint Inspection Report, with the r. 6 (7).

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) On an identified date during the inspection, resident #002 was observed seated in their specific type of wheelchair with a falls prevention intervention attached to the wheelchair but was not applied to the resident. Review of the plan of care identified they were at risk of falls and required that specific interventions. Interview with RPN #117 stated the device was supposed to be attached to the resident at all times and confirmed that care was not provided to the resident as specified in the plan. (581).

B) Resident #042 was identified as a risk for falls and had interventions in place to minimize the risk for falls. As per the plan of care, a specific intervention was to be applied when the resident was in bed to prevent injury.

On an identified date during the inspection, it was observed that there was no falls prevention device in resident #042's room.

The following day, the resident was observed by inspector #683 at 0740 hours sitting at the end of their bed in their pajamas, while a PSW entered into the room to assist them out of bed and provide morning care. There was no falls prevention device in place or in the room.

Interview with PSW #120 confirmed that the resident was to have this device in place and it was usually stored in their bedroom. PSW #120 and RPN #111 were unable to locate it on the unit.

It was confirmed by staff #111 that the resident's falls prevention device was not used as specified in the resident's plan of care.

C) Resident #043 was identified as having a risk for falls and had interventions in

place to minimize the risk for falls. As per the plan of care, the resident was to have a specific falls prevention device in good working condition, correctly positioned on them. The plan of care noted that the resident was capable of removing it, and staff were directed to "please monitor."

On an identified date during the inspection, the resident was observed by inspector #581 sitting in their wheelchair visiting with family, and their device was not attached.

Interview with RPN #117 acknowledged that this was not attached as specified in the resident's plan of care. They indicated that it should have been applied but staff may not have done so after toileting. Resident #043 was not provided the care set out in their plan of care. (581)

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

Jun 19, 2017

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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. Re-evaluate all of the bed systems in the home in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006"and document the results. At a minimum, documentation shall include type of mattress and unique mattress identifier, bed rail type, bed frame serial number, date evaluated, name of evaluator, zones tested, issues identified and follow up action taken if necessary.

2. Develop an assessment tool related to bed rail use and bed safety assessments to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006".

3. An interdisciplinary team shall assess all residents who use one or more bed rails using the bed safety assessment tool and document the assessed results and recommendations for each resident.

4. Update the written plan of care for those residents who require bed rails which have been identified after re-assessing each resident using the bed safety assessment tool. Include in the written plan of care any necessary accessories that are required to mitigate any identified bed safety hazards.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (1) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the potential for harm/risk toward 40 residents in the home, the scope of "widespread", and the Licensee's history of non-compliance (VPC) on the August 26, 2014 Follow Up Inspection Report with the r. 15 (1) a,b related to bed rails.

The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-

based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices included a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Food and Drug Administration, which outlined that decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized patient assessment using an interdisciplinary team with input from the patient and family or the patient's legal guardian. Furthermore, the document detailed guidelines for bed system evaluation and testing for potential zones of entrapment.

A. On two dates during the inspection, resident #002 was observed in bed with one bed rail raised in the guard position and one raised in the transfer position. Interview with PSW #115 stated the resident required the bed rails raised when in bed to assist with turning and repositioning. Review of the documented plan of care identified the bed rails were to be raised when in bed. Interview with RPN #117 stated that the resident only had one rail raised and did not consider the bed rail raised in the transfer position as being used. RPN #117 confirmed the resident required the bed rails for bed mobility and that a bed risk assessment was not completed for the use of the bed rails.

B. On two dates during the inspection, resident #004's bed was observed with bed rails raised. Interview with PSW #118 stated that the bed rails were raised when in bed for turning and repositioning. Review of the MDS assessment completed in 2017, confirmed the use of the rails. Interview with RN #111 confirmed the resident required the bed rails raised when in bed and that a bed rail risk assessment was not completed for the use of the bed rails.

C. On two dates during the inspection, resident #011 was observed in bed with bed rails raised. Review of the Restraint Assessment completed in 2017 identified they required the rails as a restraint; however, the Restraint Assessment completed identified they required the rails as a PASD. Interview with RN #110 stated the night registered staff stated the resident did not require the bed rails raised as a restraint but now required them as a PASD. Review of the physician order directed staff to discharge the bed rails as a restraint and directed staff to apply bed rails for an alternative reason. Interview with RN #110 stated the resident required the bed rails as a PASD and confirmed that a bed rail risk assessment was not completed when

the resident used the bed rails as a restraint nor was one completed when resident #011 required the bed rails as a PASD.

Interview with the Staff Development Coordinator confirmed that no bed rail assessments had been completed in the home to minimize the risk to residents. (581)

2. The licensee failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On two dates in 2017, resident #011 was observed in bed with bed rails raised. Review of the plan of care identified they required the rails. Review of homes bed entrapment test, dated indicated that the bed system failed zone two. Interview with the Maintenance Assistant stated that entrapment zones were assessed but failed zone two even after the home applied an intervention to the bed rail to mitigate the risk to the resident.

Review of the document that identified the beds tested for zones of entrapment with the Maintenance Assistant confirmed that 40 beds in the home failed zone two and there was no plan in place to mitigate this risk after it was identified. Interview with the Administrator on May 3, 2017, stated they were unaware that 40 bed failed zone two and identified that this was a high risk to residents' safety when in bed with the bed rails raised.

The Bed Entrapment Test document that was completed in 2017 also identified that 18 beds had a cap rail missing. The Maintenance Assistant showed the LTC Inspector one, three quarter and one assist bed rail with the cap rail missing and the surface was rough and sharp. They confirmed that the surface had the potential of scraping or causing harm to the resident's skin if they came in contact with the open surface. After consulting with the Maintenance Manager, a plan was implemented to cover the open rail cap with gorilla tape to mitigate the risk to residents.

During this inspection the Administrator provided written documentation on May 4, 2017, that 22 beds received an accessory that reduced any entrapment risks that were identified and stated a bed rail risk assessment was completed on 18 residents which indicated they did not require bed rails raised on the beds. Administrator stated that those beds would receive an accessory to reduce any entrapment risks moving forward and the bed system would be retested to ensure that all zones of entrapment pass.

The home failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment for 40 residents. (581)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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

Jun 30, 2017(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30 day of May 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA PALADINO - (A1)

Service Area Office /
Bureau régional de services : Hamilton