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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 24, 2015	2015_240506_0008	H-002169-15	Resident Quality Inspection

Licensee/Titulaire de permis

SIX NATIONS OF THE GRAND RIVER
1745 Chiefswood Road P.O. Box 5000 Ohsweken ON N0A 1M0

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

IROQUOIS LODGE NURSING HOME
1755 Chiefswood Road P.O. Box 309 Ohsweken ON N0A 1M0

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

LESLEY EDWARDS (506), BERNADETTE SUSNIK (120), JESSICA PALADINO (586), MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 8, 9, 10, 14, 15 and 16, 2015.

The following Critical Incident System inspection was completed concurrently with the RQI H-002175-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Staff Educator, Environmental Service Manager (ESM), Resident Assessment Instrument Co-ordinator (RAI), Activity Supervisor, Office Manager, Food Services Supervisor (FSS), Registered Dietitian (RD), laundry and housekeeping staff, maintenance staff, Registered Nursing staff (RNs/RPNs), Personal Support Workers (PSW), dietary staff, family members and residents.

During the course of the inspection, the inspector(s) toured the home, reviewed care and services provided on all resident home areas, reviewed records including but not limited to health care records, meeting minutes, investigation notes and polices and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
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.
19 WN(s)
9 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #037 was protected from abuse by resident #012.

i. On an identified date in March 2015 a PSW staff member witnessed an incident of abuse between resident #012 and resident #037. The incident reportedly took place in the hallway. Resident #012 was noted to be displaying this type of behaviour towards resident #037. The staff member responded by removing resident #012 from the area and taking resident #037 to another room where they could be kept in sight for the rest of the shift.
ii. It was noted that resident #012 had a history of displaying this type of behaviour and resident #037 was not capable of defending themselves against resident #012.
iii. It was noted that this was not the first reported incident of abuse towards resident #037 by resident #012.
iv. During an interview with the PSW staff who witnessed the incident, it was confirmed that they immediately reported the incident to the Registered Practical Nurse who, in turn, reported to the Registered Nurse on duty that evening. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used the resident was

assessed in accordance with evidence-based practices to minimize risk to the resident, taking into consideration all potential zones of entrapment. Evidence based practices have been identified by the Ministry of Health and Long Term Care as those identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" developed by the U.S. Food and Drug Administration and adopted by Health Canada.

Resident bed systems were assessed for entrapment zone risks in April 2014 by the home's maintenance person using a specialized tool as per Health Canada's Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006". The licensee's records maintained from the bed audit process revealed that approximately 20 out of 48 beds failed one or more zones of entrapment. Over the course of the year, the maintenance person reported that bed rails were replaced, mattress keepers applied and new mattresses installed. However, to date, the bed systems had not been re-tested to determine if the interventions applied were effective in reducing the entrapment zones previously identified. The entrapment status of the beds at the time of inspection was therefore unknown to the home staff and no steps were taken to minimize risk to the resident and residents had not been assessed for bed rail use.

A) During the inspection, a tour of all resident rooms was completed and numerous unoccupied beds were observed to have elevated bed rails for no apparent reason. Four residents (#021, #042, #036, #038) were observed to be lying in bed with one or more rails elevated on April 9, 2015. The residents' health care records were reviewed to determine if any information was available regarding their rail use requirements. Resident #042 had a requirement for 2 bed rails upon admission listed but no reason was provided. No information or direction was available to personal support workers regarding rail use specifics. Residents #038 and #021 had information in their care plan (and accessible to personal support workers) that the rails were to be kept down to prevent the resident from climbing over them, yet the rails remained up while the resident was in bed.
B) Two residents (#020, #041) had a therapeutic air mattress on their bed frames and both bed rails were in the raised position even though residents were not in bed at the time. Neither resident had any bolsters or gap fillers in place on the bed or in the room to insert between the mattress and bed rail to prevent zone 2, 3 and 4 entrapment risks. The air mattresses observed were of the style and type that would not pass any zone of entrapment due to their flexible and soft design. Neither resident had any information in their health care records to indicate if rails were to be used while in bed and if any special

interventions were required (accessories) to minimize or eliminate entrapment risks.

The home's management staff confirmed that no bed rail use assessment forms or tools had been developed to ensure that each resident was assessed consistently by an interdisciplinary team for their specific bed rail needs and bed rail hazards according to evidence-based practices. [s. 15. (1) (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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #036 was properly fed in a manner consistent with his or her needs.

Resident #036's plan of care indicated the resident was at a high nutritional risk.
i. Review of a progress note from an identified date in April 2015, revealed that the resident's family member voiced concern about the resident not eating as they did not want to attend the dining room, and was told by a registered staff member that only residents who were ill were able to receive tray service, otherwise it would not be provided.
ii. Progress notes for identified dates in April 2015, revealed the resident declined to come to the dining room. A progress note from an identified date in April 2015 indicated that the resident "did not state why [they] did not want to come to the dining room". Another progress note on an identified date in April, 2015, indicated that when the resident declined to come to the dining room, tray service was not provided.
iii. The resident's intake record had "resident refused" documented thirteen times during the month of April thus far. The plan of care indicated a fluid goal of 1,296 millilitres (ml) per day to maintain adequate hydration; however, the intake record revealed the resident was significantly under that goal nine out of the thirteen days in April 2015, ranging from 250 ml/day – 875 ml/day.
iv. Interview with registered staff and the FSS confirmed that the resident often refused to go to the dining room for meals and if so, did not receive tray service. The staff confirmed that during these instances, the resident did not receive anything to eat.
v. Registered staff and the FSS indicated that the resident received regular snacks; however, review of the plan of care revealed the resident did not receive any labelled snack items or nutritional supplements to replace the nutrition they would have received if they had eaten a meal.
vi. In an interview with the resident on April 15, 2015, they indicated that they were a private person and thus did not always like to eat in the dining room, in addition to not enjoying the loud conversations that went on around them, and stated that on those days, if they were to receive a meal tray in their room, they would eat it. [s. 3. (1) 4.]

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 residents are properly fed in a manner consistent with his or her needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe environment for its residents.

A) A gas fire place was observed to be in use in the dining room on an identified date in April 2015. No thermostat to adjust the heat setting was observed. The Environmental Services Manager confirmed that the fire place unit had an on/off switch and could not adjust the temperature setting. When the fire place was approached, the heat emanated out to table #11 used by residents for meals. The stainless steel grate surrounding the unit was too hot to touch and would have caused scalding with prolonged contact.
B) On an identified date in April 2015, two large oxygen concentrators and a medical chair scale were observed stored in the corridor outside of a room labeled "oxygen supply room" and opposite several sitting chairs used by residents. The number of items in the area at the time obstructed access to the fire exit doors labeled "C". On an identified date in April 2015, the chair scale had been removed, but the oxygen concentrators were still in the hall, but against the wall.
C) A loose raised toilet seat was observed on the toilet frame in washroom #30. The toilet seat could not be tightened to the frame and was easily pushed from side to side.
D) Wall-mounted reading lights with a long fluorescent tube bulb above and below the frame of the fixture were located over the head of each resident bed. Many light fixtures (i.e. #12 & #17) were observed to be used as a shelving unit for stuffed toys, pictures and other objects. Objects on top of the tube lights can cause bulb breakage causing shrapnel injury and small amounts of mercury to be released and stuffed toys can present a fire hazard. Lighting fixtures were also noted to be emanating less illumination when they were blocked. [s. 5.]

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 the home was a safe environment for its residents, to be implemented voluntarily.

WN #5: 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. (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 has failed to ensure that the care set out in the plan of care was provided to resident #031 as specified in their plan.

Resident #031's plan of care directed staff to apply a chair alarm to the resident's wheelchair while up in their wheelchair as the resident is at high risk for falls. An observation of the resident on an identified dare in April 2015 confirmed that the resident did not have the chair alarm applied to their wheelchair. Interview conducted with the registered staff on an identified date in April 2015 confirmed that the resident's chair alarm was not applied to the resident's wheelchair and that the staff did not follow the residents plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that each resident's plan of care was reviewed and revised when the resident's care needs changed.

A) Resident #016's documented plan of care and kardex indicated that the resident was able to dress independently.
i. The Minimum Data Set (MDS) assessment dated as completed on an identified date in February 2015, indicated the resident required extensive assistance with dressing and one person physical assistance.
ii. Interview with PSW staff confirmed that the resident required assistance with dressing. The resident's plan of care was not revised when their care needs changed.

B) Resident #030's documented plan of care indicated that the resident was to use a bed alarm, chair alarm, or motion sensor alarm when in their bed/chair due to being at a high risk for falls.
i. The resident was observed on an identified date April 2015, in a recliner chair and later in a wheelchair without a chair alarm. Interview with PSW and registered staff confirmed that the resident no longer required the use of a chair alarm. Staff confirmed the plan of care was not updated when the resident's care needs changed. [s. 6. (10) (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 care set out in the plan of care is provided as per the plan and to ensure that when residents care needs change the plan of care is reviewed and revised, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that doors leading to unsecure outdoor areas were equipped with an audible door alarm.

The fire exit doors located at the end of the Davis corridor, the dining room, family room and the main foyer were not equipped with an audible alarm at the door. The doors were tested with the Environmental Services Manager who confirmed that none of the doors to unsecured outdoor areas had an audible alarm at the door, just at the nurse's station. The alarm panel at the nurse's station was a separate unit that was not part of the resident-staff communication and response system, but was sufficient in indicating the location of the breached exit door. [s. 9. (1)]

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 doors leading to unsecure outdoor areas were equipped with an audible door alarm, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to ensure that the lighting requirements set out in the lighting table were maintained.

The lighting requirements as set out in the table identified as "all other homes" applies to this home as it was built prior to 2009. Various areas of the home were tested such as a corridor, several resident washrooms, several resident bedrooms, the dining room and the activity room. Other areas were not measured. The areas identified as non-compliant was limited to the resident bedrooms.

Two different types of resident rooms were measured (a private and a semi-private room) as all had similar lighting fixtures in style and number. Light fixtures were measured using a portable digital light meter (Amprobe L-120), held 30 inches above and parallel to the level of the floor. Outdoor lighting conditions were cloudy at the time of measurement and all efforts were made to close blinds and drapery to block out the natural light.

Resident rooms were each equipped with one ceiling mounted two bulb fixture with an opaque glass lens and an over-bed light. All available lights were turned on and allowed to warm up for approximately 5 minutes prior to taking measurement.

A) In room #7; a semi-private room, upon entering the room the lighting was measured at 83.4 lux. Directly under each of the 2 ceiling fixtures located over the foot of the beds, the level of illumination was 159 lux and 186 lux. The area in front of the closet beside bed #1 was measured at 215 lux and the closet beside bed #2 was measured at 273 lux. The area between the two beds was 273 lux. The illumination level was acceptable near the beds when the over bed lights were on; however, the illumination level dropped the further away the meter was held from the over bed lights.
In room #16; a private room, upon entering the room, the lux level was 75. Directly underneath the ceiling fixture the lux was between 175 and 185. The area beside the bed (near the window with drapes drawn) the lux was 139 and the area at the foot of the bed was 152 lux.

A minimum level of 215.28 lux is required in all bedrooms for general room light, especially in areas of the bedroom where activities of daily living occur such as dressing, sitting, walking, watching television etc. [s. 18.]

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 the lighting requirements set out in the lighting table were maintained, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy related to promotion of zero tolerance of abuse and neglect of residents was complied with related to s.20(2)d, the duty under section 24 to make mandatory reports.

i. The home's policy [Abuse and Neglect Prevention Program - Section 4:1] last reviewed in January 2014, directed staff to immediately report to their Supervisor, the Charge Nurse or the Manager if there were reasonable grounds to suspect that an abuse of a resident has occurred.
ii. On an identified date in March 2015, resident #012 was observed by a PSW staff to inappropriately touch resident #037. The PSW immediately reported the incident to the RPN who then reported it to the RN.
iii. The nursing staff documented in resident #037's progress notes that the incident was reported on March an identified date in March 2015, but did not immediately notify their supervisor or the manager.
iv. The incident was not reported to the Administrator/Director of Care/designate until two days later and the critical incident report was not submitted to the Director until two days later. [s. 20. (2) (d)]

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 the home's policy related to promotion of zero tolerance of abuse and neglect of residents was complied with related to s.20(2)d, the duty under section 24 to make mandatory reports, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing was provided within 10 days of receiving Family Council advice related to concerns or recommendations.

During a review of the Family Council minutes for the home, it was confirmed that no written responses were provided to the Council within 10 days of the Council having expressed concerns or recommendations to the licensee regarding the food, in March 2015. This information was confirmed by the Family Council representatives and the Administrator. [s. 60. (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 a response in writing is provided within 10 days of receiving Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the advice of the Residents' Council or Family Council was sought out when developing and carrying out the annual satisfaction survey, and in acting on its results.

Interview with a Residents' Council member on an identified date in April 2015, and interview with the Family Council President on an identified date in April 2015, revealed that the Councils were not given the opportunity to participate in developing the home's satisfaction survey. This was confirmed by the Administrator on April 15, 2015. [s. 85. (3)]

2. The licensee failed to ensure that the results of the Residents' Council or Family Council was sought out when developing and carrying out the annual satisfaction survey, and in acting on its results.

The licensee did not make available to the Residents' Council or Family Council the results of the satisfaction survey in order to seek the advice of the Councils about the survey. This information was confirmed by the Administrator. [s. 85. (4) (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 to ensure that the advice of the Residents' Council or Family Council is sought out when developing and carrying out the annual satisfaction survey, and in acting on its results and to ensure that the advice of the Residents' Council or Family Council is sought out when developing and carrying out the annual satisfaction survey, and in acting on its results, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures or schedules were in place for remedial or preventive maintenance.

A) Although the licensee had a procedure in place regarding the condition expectations for exterior areas, no schedule was in place to address the observed conditions. The licensee's procedure titled "Exterior Check" dated July 2008 required staff to ensure that exterior areas of the building, including walkways were kept safe and in good repair. A portion of the exterior walkway leading to a covered sitting area used by residents was in disrepair. The concrete was broken down into many small pieces. An area in front of the glass exit doors leading into the courtyard from the activity room was depressed, leaving a raised edge. The poured concrete walkway just outside an exit off the Davis wing had to be excavated due to heaving and the concrete chunks were piled up just outside the door. The Environmental Service Manager (ESM) identified that it was scheduled for repair, but did not have any specific date. The area outside of the Issac exit was not however used by residents and was locked. The other two areas however were observed to be used by residents at the time of the visit. Both areas posed a tripping hazard. The ESM did not have any schedules in place to repair the two identified areas.

B) The licensee did not ensure that schedules were in place for preventive maintenance throughout the home. The licensee's maintenance program was largely remedial, relying on nursing and dietary staff to report disrepair. In discussion with the maintenance person, a small portion of the program was preventive and completed by the maintenance person with respect to beds, fire safety systems, boilers, heating and air conditioning and electrical equipment and major systems. The ESM was not able to provide a current schedule of audits at the time of inspection to determine if anyone had audited for the condition of internal surfaces such as furnishings, walls, floors, doors, windows, fixtures in common areas, resident bedrooms, bathrooms, dining room and tub room. Completed audits for the above noted areas was provided, but from many years ago. The following issues were identified which the ESM was not aware of and therefore did not have a schedule of repair:

a) Room #2, 18 – night table edges in poor condition
b) Room #7 – exhaust timer not functioning
c) Room #21, 22, 23 – exhaust motors too noisy
d) Room #5 – over bed table edges in poor condition
e) Room #7 – flooring material split and lifting in bathroom [s. 90. (1) (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 procedures or schedules were in place for remedial or preventive maintenance, to be implemented voluntarily.

WN #12: 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 did not ensure that the resident-staff communication and response system was available in every area accessible by residents. Activation stations were not provided in the hair salon, family room or outdoor courtyard (at exterior entrance). [s. 17. (1) (e)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care for resident #016 was based on an interdisciplinary assessment of the resident with respect to the use of bed rails.

During observation of resident #016's room over the course of two days during this inspection, it was noted that the resident had two one-quarter rails elevated on the bed while in bed.
i) Registered staff interviewed confirmed that the resident used two rails while in bed to assist with mobility and that the bed rails did not restrict the resident from exiting the bed.
ii) The MDS assessment dated as completed on an identified date in December 2014, indicated the use of bed rails for the resident to assist with bed mobility or transfer.
iii) The document that the home refers to as the care plan, and the kardex used by the PSWs to direct care, did not include identification of the use of a bed rail for mobility as indicated in the MDS assessment completed for the resident and confirmation of bed rail use by staff. [s. 26. (3) 18.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following were developed for the needs of residents with responsive behaviours: (4) Protocols for the referral of residents to specialized resources.

i. Resident #012 was noted to have a longstanding history of displaying responsive behaviours towards other staff and co-residents.
ii. Resident #012 was involved in an incident of abuse directed towards resident #037 in December 2014.
iii. It was noted that an application was initiated for resident #012 on an identified date in January 2015, for admission to a facility that has a specialized unit related to the resident's responsive behaviours.
iv. During a review of resident #012's health file, it was noted that this referral was not completed and submitted until a date in March 2015. This resulted in a delay of more than six weeks from initiation to completion. During that time period the resident continued to pose a risk to other residents and staff at the home.
v. During interviews with the Administrator and the Staff Educator, it was confirmed that this form should have been completed and submitted much earlier.
vii. On an identified date in March 2015, another incident of responsive behaviour by resident #012 towards a co-resident occurred.
viii. During a review of the home's policy and procedure [Responsive Behaviours - dated as last reviewed February 2014], it was confirmed that there was no protocol for staff to follow related to the referral of residents to specialized resources as required. [s. 53. (1) 4.]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing was provided within 10 days of receiving Residents' Council advice related to concerns or recommendations.

During a review of the Residents' Council minutes for the home, it was confirmed that no written response was provided to the Council within 10 days of the Council having expressed concerns or recommendations to the licensee. It was confirmed by the Activity Supervisor that responses in writing have not been provided to the Council within 10 days. [s. 57. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, (ii) height upon admission and annually thereafter.

The home did not ensure that residents' heights were taken annually as evidenced by review of the resident's clinical records. This was confirmed by the registered staff and FSS. [s. 68. (2) (e) (ii)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #016 and #037 were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, when they experienced a weight change of 5 per cent (%) of body weight or more over one month.

A) Resident #016 experienced a significnat weight loss from January to February, 2015. A referral was sent to the FSS and RD on an identified date in February 1015 for the significant weight loss. Documentation and interview with the FSS and RD confirmed that as of April 10, 2015, the resident had not yet been assessed by the FSS or RD.

B) Resident #037 was at a high nutritional risk according to their plan of care. They experienced a significant weight loss from October to November, 2015. A referral was sent to the RD on an identified date in November 2014 for the significant weight loss; however, documentation and interview with the FSS and RD confirmed that the resident was not assessed until 23 days after the initial referral was made. The resident continued to lose another kilogram as of December 2015. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were developed and/or implemented for cleaning and disinfection of resident care equipment (non-critical devices such as urinals, bed pans and wash basins) in accordance with evidence based practices. Evidence based practices related to cleaning such devices are identified in a document titled "Cleaning, Disinfection and Sterilization of Medical Equipment/Devices", 2013 developed by the Provincial Infectious Diseases Advisory Committee.

According to the home's bed pan and urinal handling procedure titled "Sanitation for Night Shift", dated August 2014, night shift personal support workers were tasked to collect "all clean" bed pans and urinals from resident rooms each Monday night for routine cleaning and disinfecting in the soiled utility room and to ensure they were labeled. According to the home's bed pan handling procedure (Activities of Daily Living, Bed Pan – Giving and Removal, 4.10, June 2010), all personal support workers were required to remove soiled bed pans from the resident room after use and clean and disinfect them in the soiled utility room and return a clean bed pan to the resident room.

Urinals were required to be rinsed with cold water after use and returned to the bedside or stored in a bag in the bathroom. If soiled, the expectation was that they be properly cleaned in the soiled utility room. The processes were established to ensure that once per week, devices received a deep clean regardless of whether used or not and that the devices were cleaned and disinfected after each use.

The wash basin handling procedure (Sanitation for Night Shift, August 2014) required that night shift personal support workers collect 5 wash basins per night, according to a rotational schedule and have them deep cleaned in a mechanical washer/disinfection machine. The basins were also to be checked for a label (room #). However, the procedure did not describe how each basin would be cleaned after each use and how the scale accumulations would be removed.

According to the observations made on an identified dates in April 2015, staff did not implement the procedures that were developed for cleaning and disinfecting the non-critical devices.

A) Visibly soiled or dusty bed pans (some with scale) were found unlabeled and stored on top of toilet tanks in rooms #1, #2, #7, #15, #16, #17, #18, #19, #23, #24 (in hand sink), #26 (on top of dusty cabinet), #27 and #28 over a 2-day period (April 9 & 10, 2015). The visibly soiled bed pan in room #16 was found on April 10, 2015 to be cleaner in appearance with clear water in it. A bed pan was observed in the hand sink filled with soapy water and fecal material in room #24 on April 9, 2015 and observed to be cleaner in appearance and sitting on top of a commode chair on April 10, 2015.
B) Stainless steel wash basins with minor to moderate hard water scale build-up were found in rooms #2, #4, #5, #16, #18, #27 and #28. Some were in shared resident washrooms without a label. The scale is an indication of a lack of routine de-scaling and/or leaving water to dry in them. Basins receiving a daily cleaning and proper drying would not form scale. Scale formation allows bacteria a place to hide and be re-introduced into clean water upon re-use.
C) Urinals without a label identified to be stored on top of a toilet tank in shared resident washroom #34 (and visibly soiled) and #26 on both April 9 and 10, 2015. [s. 87. (2) (b)]

2. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

The licensee's housekeeping manual did not consist of any instructions or direction for

any staff member to take with respect to managing lingering offensive odours and who would be responsible for ensuring that odours would be mitigated as much as possible. During the inspection, lingering offensive odours related to bodily fluids (feces and urine) were noted throughout the day on April 8 and 9, 2015 in rooms #20, #25 and #30. When the rooms or washrooms were checked, the exhaust fan was not running and bodily fluids were seen on the surface of the floor, toilet, commode chair or on personal care articles such as bed pans (slipper pans). It was noted that personal support workers did not clean the bodily fluids from the devices or surfaces as required and bodily fluids remained on surfaces until housekeeping staff returned to the rooms the following day. The devices such as bed pans did not receive any cleaning over the two day observation period. [s. 87. (2) (d)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During a review of the medication room and interviews with RPN staff, it was confirmed that the back up supply of controlled medications prescribed for residents were stored in a locked emergency box (that was not stationary) within the locked medication room. The controlled substance were not stored in the manner required. [s. 129. (1) (b)]

Issued on this 28th day of April, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LESLEY EDWARDS (506), BERNADETTE SUSNIK (120), JESSICA PALADINO (586), MARILYN TONE (167)
Inspection No. / No de l'inspection :	2015_240506_0008
Log No. / Registre no:	H-002169-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 24, 2015
Licensee / Titulaire de permis :	SIX NATIONS OF THE GRAND RIVER 1745 Chiefswood Road, P.O. Box 5000, Ohsweken, ON, N0A-1M0
LTC Home / Foyer de SLD :	IROQUOIS LODGE NURSING HOME 1755 Chiefswood Road, P.O. Box 309, Ohsweken, ON, N0A-1M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SUSAN Mt. PLEASANT

Ontario

Ministry of Health and Long-Term Care

Ministére 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 SIX NATIONS OF THE GRAND RIVER, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that all residents including resident #037 are protected from abuse.

1. The home is to review and revise as appropriate their Abuse Policy.
2. The home is to provide education to all staff on the abuse policy and their requirements under the legislation.

Grounds / Motifs :

1. Previously issued as a VPC in January 2015.

The licensee has failed to ensure that resident #037 was protected from abuse by resident #012.

i. On an identified date in March 2015 a PSW staff member witnessed an incident of abuse between resident #012 and resident #037. The incident reportedly took place in the hallway. Resident #012 was noted to be displaying this type of behaviour towards resident #037. The staff member responded by removing resident #012 from the area and taking resident #037 to another room where they could be kept in sight for the rest of the shift.
ii. It was noted that resident #012 had a history of displaying this type of behaviour and resident #037 was not capable of defending themselves against resident #012.
iii. It was noted that this was not the first reported incident of abuse towards resident #037 by resident #012.
iv. During an interview with the PSW staff who witnessed the incident, it was confirmed that they immediately reported the incident to the Registered Practical Nurse who, in turn, reported to the Registered Nurse on duty that evening.
(167)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 15, 2015

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:

1. Re-assess all bed systems using the Health Canada Guidelines tilted "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006".
2. Implement interventions to reduce or eliminate entrapment zones for those residents who have a therapeutic surface on their bed frame and who use one or more bed rails. Document the intervention in the residents' plan of care.
3. All residents who use a bed rail shall be assessed for bed rail use by employing the guidelines identified in the FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
4. The result of the assessment shall be documented in the residents' plan of care and the information regarding the resident's bed rail use (which side of bed, size of rail, how many rails and why) shall be clearly identified so that health care staff have clear direction.
5. All health care workers shall receive education on the hazards of bed rail use.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used the resident was assessed in accordance with evidence-based practices to minimize risk to the

resident, taking into consideration all potential zones of entrapment. Evidence based practices have been identified by the Ministry of Health and Long Term Care as those identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" developed by the U.S. Food and Drug Administration and adopted by Health Canada.

Resident bed systems were assessed for entrapment zone risks in April 2014 by the home's maintenance person using a specialized tool as per Health Canada's Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006". The licensee's records maintained from the bed audit process revealed that approximately 20 out of 48 beds failed one or more zones of entrapment. Over the course of the year, the maintenance person reported that bed rails were replaced, mattress keepers applied and new mattresses installed. However, to date, the bed systems had not been re-tested to determine if the interventions applied were effective in reducing the entrapment zones previously identified. The entrapment status of the beds at the time of inspection was therefore unknown to the home staff and no steps were taken to minimize risk to the resident and residents had not been assessed for bed rail use.

A) During the inspection, a tour of all resident rooms was completed and numerous unoccupied beds were observed to have elevated bed rails for no apparent reason. Four residents (#021, #042, #036, #038) were observed to be lying in bed with one or more rails elevated on April 9, 2015. The residents' health care records were reviewed to determine if any information was available regarding their rail use requirements. Resident #042 had a requirement for 2 bed rails upon admission listed but no reason was provided. No information or direction was available to personal support workers regarding rail use specifics. Residents #038 and #021 had information in their care plan (and accessible to personal support workers) that the rails were to be kept down to prevent the resident from climbing over them, yet the rails remained up while the resident was in bed.
B) Two residents (#020, #041) had a therapeutic air mattress on their bed frames and both bed rails were in the raised position even though residents were not in bed at the time. Neither resident had any bolsters or gap fillers in place on the bed or in the room to insert between the mattress and bed rail to prevent zone 2, 3 and 4 entrapment risks. The air mattresses observed were of the style and type that would not pass any zone of entrapment due to their

flexible and soft design. Neither resident had any information in their health care records to indicate if rails were to be used while in bed and if any special interventions were required (accessories) to minimize or eliminate entrapment risks.

The home's management staff confirmed that no bed rail use assessment forms or tools had been developed to ensure that each resident was assessed consistently by an interdisciplinary team for their specific bed rail needs and bed rail hazards according to evidence-based practices.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2015

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
Performance Improvement and Compliance 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

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

and the Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

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

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
Direction de l'amélioration de la performance et de la conformité
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 24th day of April, 2015

Signature of Inspector / Signature de l'inspecteur : Lesley Edwards

Name of Inspector / Nom de l'inspecteur : Lesley Edwards

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