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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 6, 2014	2014_189120_0030	H-000678-13	Follow up

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

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

LINHAVEN
403 Ontario Street, St. Catharines, ON, L2N-1L5

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 12, 2014

An inspection (2013-189120-0061) was previously conducted on August 29, 2013 at which time two Orders were issued, one related to bed safety and the other to the resident-staff communication and response system. During this follow-up visit, the conditions laid out in the Orders were met for the most part, however additional issues were identified during this visit. See below for details.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Building Services Supervisor and registered staff.

During the course of the inspection, the inspector(s) tested the resident-staff communication and response system in the Secord Home area, observed resident bed systems, reviewed the home's bed safety audit reports, reviewed registered staff meeting minutes, reviewed resident health records and policies and procedures related to bed safety, resident assessments and the resident-staff communication and response system.

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

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Where bed rails are used, the resident's have not been assessed according to prevailing practices to minimize risk to the resident.

Discussions were held with the Director of Care and a registered staff member who explained that residents were being assessed quarterly for rail use using their policy PCS01-002 titled "Personal Assistance Services Devices". It was understood that registered staff complete a quarterly questionnaire in their computerized "Point Click Care" program. The assessment was to be completed by various registered staff and their decisions discussed informally during meetings with the Director of Care. The registered staff member reviewed with the inspector the forms used and the questions answered using Point Click Care. They also confirmed that they did not use any formal decision-tree or guidance tool in making their decisions with respect to bed rail safety, it was based on their skill and experience. In reviewing the process, it became evident that the guidelines identified in the prevailing practices known as the "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings, April 2003" had not been incorporated. The guideline has been endorsed by Health Canada and is a companion guide to the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008".

The home's current questionnaire for bed rail use is limited and fails to incorporate many of the questions identified in the guideline. Management staff did not ensure that a consistent approach was used by all registered staff during rail use assessments. The current assessment was not truly interdisciplinary and the assessment did not include a risk-benefit assessment that identified why other care interventions were not appropriate or not effective if they were previously attempted and determined not to be the preferred treatment of the residents. The plan of care did not present clear directions for further investigation of less restrictive care interventions. The documentation did not describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet the resident's assessed needs. [s. 15(1)(a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents who use bed rails are assessed in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).

Findings/Faits saillants :

1. The licensee did not develop emergency plans for dealing with the loss of one or more essential services, specifically the loss of the resident-staff communication and response system. The administrator provided their policy EMLH02-003 titled "Urgent Maintenance Services" which does not address the procedures for staff to take in the event that the resident-staff communication and response system should be unavailable. [s. 230(4)1.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 15. (1)	CO #001	2013_189120_0061	120
O.Reg 79/10 s. 17. (1)	CO #002	2013_189120_0061	120

Issued on this 6th day of June, 2014

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