Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 27, 2017	2016_346133_0042	020620-16, 026727-16, 029174-16	Follow up

Licensee/Titulaire de permis

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON N3H 5L8

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

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON K1K 0S6

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 14,15,16, 20,21,22 - 2016

This follow up inspection was related to a compliance order regarding the door alarm system, a compliance order regarding maintenance of the home, and a compliance order regarding bed rail use.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the Director of Care, the Maintenance Supervisor, an Extendicare Assist Nurse Consultant, the RAI coordinator, registered and non-registered nursing staff, technicians with the home's contracted HVAC service provider, and residents. During the course of the inspection, the Inspector also communicated via email with an Extendicare Environmental Services Consultant.

During the course of the inspection, the Inspector observed resident bedrooms and common areas throughout the home, evaluated the new door alarm system, reviewed documentation related to bed system evaluations where bed rails are in use and reviewed components of selected resident's health care record including the "bedrail and entrapment risk assessment" and plan of care. In the company of the Director of Care and an Extendicare Assist Nurse Consultant, the Inspector observed as the RAI coordinator conducted testing of specified potential zones of entrapment on selected bed systems. The Inspector verified the temperature of the hot water serving the bathtub in the South tub room and reviewed the November 2016 and December 2016 Water Temperature Log sheets. The Inspector verified the air temperature in specified resident's bedrooms and reviewed the December 2016 Air Temperature and Humidity Log sheet. The Inspector reviewed the Extendicare "Missing personal clothing" policy #HL-06-03-12 (last updated September 2015) and the associated Extendicare "Complaints" policy #09-04-06 (current version: June 2010). The Inspector reviewed the Extendicare "Preventative Maintenance Program" policy #MN-02-01-01 and associated procedures related to the HVAC system. The Inspector reviewed the Maintenance Request Log book located at the South nurses' station. The Inspector reviewed the Extendicare "Water Temperature" policy #ADMI-04-04-10 (implemented January, 2006).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Safe and Secure Home

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2016_346133_0031	133
O.Reg 79/10 s. 9. (1)	CO #001	2016_346133_0027	133

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The licensee has a history of non-compliance with O. Reg. 79/10, s. 15 (1). As a result of the Resident Quality Inspection conducted in July and August 2016, #2016_286547_0019, the licensee was served with a compliance order. As a result of the Resident Quality Inspection conducted in December 2015, # 2015_286547_0025, a Written Notification was issued. The non-compliance presented below is widespread and presents potential risk to all residents with bed rails in use. As a result of the compliance history, scope of non-compliance and severity of non-compliance, a compliance order will be served to the licensee.

In August 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones one -seven), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones one -

four), and prescribes test tools (cone and cylinder tool with spring scale) and methods to measure and assess gaps in some of the potential entrapment zones (Zones one - four).

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

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003) (FDA 2003 clinical guidance document). This document provides necessary guidance in establishing a clinical assessment where bed rails are used and directs that the automatic use of bed rails is to be avoided as this may pose unwarranted hazards to resident safety. In this document, it is indicated that any decision to use or discontinue the use of bed rails should be made within the context of an individualized resident assessment using an interdisciplinary team. The individual assessment is to include numerous factors including the resident's medical needs, sleep habits, and mobility (in and out of the bed). The sleeping environment assessment includes elements or conditions that may affect the resident's ability to sleep, such as comfort, appropriate bed and medical stabilization. The decision to use bed rails should include a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. If clinical and environmental interventions have proven unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of interventions or of not using them, bed rails may be used. Documentation of the risk-benefit assessment should be in the resident's health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly. The document directs that bed rail use should be accompanied by a care plan (treatment program) and information to be included in the care plan is specified, including clear direction for further investigation of less restrictive care interventions if the bed rail use is for treatment of a medical symptom or condition, and options for reducing the risk of rail use and education for the resident about possible bed rail danger if the bed rail use is for resident mobility and/or transferring.

Related to resident #001:

It was ascertained that at the time of the inspection, the resident was not assessed in accordance with prevailing practices, nor was his/her bed system evaluated in accordance with evidence based practices, to minimize risk to the resident.

As observed by the Inspector on December 20th, 2016 at 10:00 hours, resident #001's bed system included a therapeutic air mattress (ZephAire therapeutic support surface) and two functional full length bed rails on the bed frame. A Personal Support Worker (PSW, #S101) informed the Inspector that the left rail was always kept in the up position when resident #001 was in bed, and the right rail was raised to assist with positioning during the provision of care. The left rail was covered by a bumper pad and the right rail was bare at the time of observation.

On December 20th, 2016, the Inspector met with the Director of Care (DOC), an Extendicare Assist Nurse Consultant (the consultant, #S102) and the RAI coordinator to discuss corrective actions taken as a result of the Compliance Order served to the licensee as a result of inspection #2016_286547_0019. The Inspector was informed that all residents had been assessed with regards to bed rail use and all bed systems had been evaluated, in advance of the compliance date of September 16th, 2016. The Inspector inquired specifically about resident #001, in light of the full rails and therapeutic air surface in use. The Inspector was informed that resident #001 was recently admitted to the home. The DOC explained that in advance of resident #001's admission, on November 28, 2016, she went to the basement, found a functional air mattress and directed it be put into use for resident #001 as per her understanding of the resident's clinical needs. The DOC confirmed that she did not fill out a "bed/mattress change form", which the home implemented as a result of the Compliance Order, to track bed moves or changes and to initiate bed system evaluations. The DOC explained that she later learned that there had been no bed frame in the bed space designated for resident #001 when she directed that the air mattress be put into use. A bed frame with full bed rails that had also been down in the basement was put into use with the air mattress for resident #001. It could not be determined who had decided to put that particular frame with full rails into use for resident #001. The RAI coordinator indicated that he was on vacation at the time of resident #001's admission. The RAI coordinator was the only person trained to evaluated bed systems at the home at that time and at the time of the inspection. The RAI coordinator confirmed that he did not evaluated the bed system in place for resident #001 upon his return from vacation. The RAI coordinator indicated that he was unsure why he did not evaluate the bed system, and speculated that perhaps it was because it was an air mattress. As per the HC guidance document, bed systems

with bed rails and therapeutic air surfaces are technically exempt from Zone two, three and four testing. It is assumed that such a bed system will fail the testing due to the highly compressible nature of the surface, unless the air mattress is of a design with a firm perimeter or reinforced side walls. As per the HC guidance document, bed systems using therapeutic air surfaces are not exempt from zone one (the space between the rails) testing. As well, the technical exemption does not preclude the evaluation of Zone six, the space between the end of the rail and the side edge of the headboard or footboard or of Zone 7, the space between the inside surface of the headboard or footboard and the end of the mattress.

The RAI coordinator provided the Inspector with the resident #001's "bed rail and entrapment risk assessment". It was noted that the assessment was initiated the day following the resident's admission to the home, on November 29th, 2016. The assessment identified that resident #001 was at risk of bed entrapment (section B1) due to seven selected items (section A) that could contribute to the resident's individualized risk for bed entrapment. The RAI coordinator explained that the bed rail and entrapment risk assessment was mandatory for the admission process for all new residents. The RAI coordinator explained that the assessment had been initiated by Registered Nurse #S102 and that he (the RAI coordinator) had locked it, without making any changes or additions to it, on December 20th, 2016. The assessment made no reference to the use of bed rails for resident #001. The resident was not assessed using an interdisciplinary team, nor was the decision to use bed rails for resident #001 approved by an interdisciplinary team. The RAI coordinator agreed that the assessment did not demonstrate any rationale for use of bed rails for resident #001. The RAI coordinator provided the Inspector with resident #001's plan of care. The plan of care did not reference use of bed rails for resident #001.

The consultant indicated that the right rail on resident #001's bed system would be fixed into place that afternoon. As well, the consultant indicated that the resident would be observed and assessed while in bed over a period of days to determine if the left rail was truly necessary. The Inspector was informed that the resident was known to move his/her arms while in bed but not to move his/her body while in bed.

Related to the assessment of residents for bed rail use in accordance with prevailing practices:

A process for assessing residents for bed rail use was implemented in response to the Compliance Order served to the licensee as a result of inspection #2016_286547_0019.

It was ascertained that the process in place was not in accordance with prevailing practices (FDA 2003 clinical guidance document).

On December 20th, 2016, in discussion with the DOC, the consultant and the RAI coordinator, the RAI coordinator indicated that he had done the majority of the resident assessments, with the "Bedrail and Entrapment Risk Assessment". The RAI coordinator explained that he was well acquainted with the existing residents' sleep habits, mobility in bed and comfort while in bed, and felt he could answer the related questions accurately. The RAI coordinator acknowledged that for new residents, such as resident #001, staff are not well acquainted with such factors. The RAI coordinator, the DOC and the consultant noted that the assessment process does not direct staff to observe the resident while in bed, and therefore it could be difficult for staff to accurately answer questions about a new residents' sleep habits, mobility in bed and comfort while in bed. As well, it was noted that there was no process in place to conduct individualized resident assessments by an interdisciplinary team, or to have the decision to use bed rails approved by an interdisciplinary team, as per the FDA 2003 clinical guidance document.

On December 22nd, 2016, the RAI coordinator acknowledged a lack of clarity with regards to certain aspects of the "Bedrail and Entrapment Risk Assessment" questions.

Part B of the assessment is about building the plan of care based on the risk assessment conducted in Part A. The first question in Part B asks "Is the Resident at risk for bed entrapment?". Looking at resident #015 vs. resident #013's assessment, resident #015 had nine items selected, in Part A, that would contribute to the resident's individualized risk for bed entrapment, yet it was indicated she/he was not at risk of bed entrapment. Resident #013 had two items selected in Part A, yet it was indicated that she/he was at risk of bed entrapment. The RAI coordinator explained that resident #015 was in a high low bed with a type of rail that had passed the entrapment zone testing, so he did not feel he/she was at risk of entrapment, despite all of the identified risk factors in Part A. The RAI coordinator explained that resident #013 was in a bed with full rails that failed the entrapment testing at the time of the assessment, so he felt she/he was at risk of entrapment. It was noted that when the question was answered with a Yes, direction related to referrals to appropriate disciplines or teams to determine alternatives to bed rails, and planning for a safe bed system were generated. The risk assessment conducted in Part A was not considered by the RAI coordinator when answering the question, only the results of the bed system evaluations. The risk assessment in Part A

does not reference bed system evaluations, it is exclusively related to the resident. As discussed with the RAI coordinator, entrapments may occur despite the fact that a potential zone of entrapment has been deemed to pass the prescribed entrapment zone testing. As well, as per the 2003 FDA clinical guidance document, residents are to be assessed prior to the implementation of bed rail use.

The second question in Part B asks "Is the resident independent for bed mobility AND has not had a previous fall from bed AND is able to effectively call for assistance when in bed?". This question further probes for the resident's risk of entrapment. Looking at resident #014's (referenced as resident # 039 in the Compliance Order issued as a result of inspection #2016_286547_0019) assessment, the RAI coordinator had answered "Yes" to the question. The Inspector was aware that resident #014 was not able to effectively call for assistance when in bed. The question should have been answered with a "No". The RAI coordinator explained that he would answer "Yes" to the first two parts of the question and "No" to the last part. The RAI coordinator explained as there were more "Yes" than "No", he answered "Yes" to the overall question. As a result, the next question in the assessment was related to the resident's independence through the use of bed rails for positioning. When the RAI coordinator changed the answer to a "No", the next question was then about planning for a safe bed system.

The RAI coordinator indicated that he would seek retraining on the use of the "Bedrail and Entrapment Risk Assessment".

Related to the evaluation of all bed systems in the home with bed rails in use in accordance with evidence-based practices:

A process for evaluating bed systems was implemented in response to the Compliance Order served to the licensee as a result of inspection #2016_286547_0019. It was ascertained that the process in place was not in accordance with evidenced-based practices (HC guidance document)

It was ascertained that none of the 21 bed systems with bed rails in use had been evaluated in accordance with the HC guidance document. The bed systems had not been correctly evaluated with regards to Zone two. Zone two is the gap under the rail between a mattress compressed by the weight of a head and the bottom edge of the rail at a location between the rail supports, or next to a single rail support. Furthermore, it was ascertained that the nine bed systems with rotating assist rails had also been incorrectly evaluated with regards to Zone three and Zone four. Zone three is the space

between the inside surface of the rail and the mattress compressed by the weight of a resident's head. Zone four is the gap that forms between the mattress compressed by the resident and the lowermost portion of the rail, at the end of the rail. The space poses a risk of entrapment of a resident's neck.

On December 20, 2016, the Inspector worked with the DOC and the consultant to review documentation related to past and current bed system evaluations. It was noted that in the past, the bed system in use for resident #002 and resident #003, with full bed rails, had failed Zone two testing. The Inspector was informed that full length rail pads had been applied as corrective action. It was noted that the two bed systems had since been re-evaluated by the RAI coordinator, and were deemed to have passed the Zone two testing process. As rail pads do not affect the Zone two gap, it was unclear to the Inspector how this intervention could have affected the Zone two test results

As per the HC guidance document, the Zone two test is the only test not always done with the bed in the flat position. The test assesses the potential for head entrapment under the rail. Before the test is done, the correct testing position must be found. With the bed in the flat position, the Zone two space is located. Then, the bed is to be articulated (adjusting the head and knee sections) while the Zone two space is observed. As the bed is articulated, the Zone two space may get bigger, smaller, or stay the same. The position is to be adjusted until the position which makes the largest opening in zone two is found. If the size of the opening gets smaller, or does not change, the bed is to be returned to the flat position to do the test. Once the proper position is found, the test is to be done with the cone (independent of the cylinder attachment) and the spring scale. The safety strap is to be used to secure the cone to the rail being tested, the cone is then inserted, small end first, into the gap between the mattress and the lower edged of the rail, between the rail supports. The cone must be allowed to compress the mattress. Then, the spring scale is to be attached to the loop on the cone. The spring scale is to pulled using 12 lbs of force at any angle that increases the chances of the cone going through the space. If the large end of the cone enters the space under the rail, or passes under the rail, this space fails the test.

On December 21, 2016, the Inspector requested that the home's RAI coordinator demonstrate the process that he had used to test Zone two on resident #002's bed system. In the presence of the Inspector, the DOC and the consultant, the RAI coordinator demonstrated that he used the cone with the cylinder to do the test for Zone two. He held the end of the cylinder in his hand and the small end of the cone was positioned in the space between the right rail and the mattress on resident #002's bed.

The cone did not go down into the space. The RAI coordinator concluded that Zone two had passed the test.

The RAI coordinator confirmed that he had done all Zone two tests with the cone attached to the cylinder, and without the use of the spring scale. As well, the RAI coordinator confirmed that he had always done Zone two tests with the bed in the flat position.

The testing process for Zone two, as per the HC guidance document, was then reviewed. The RAI coordinator raised the head of resident #002's bed and it was observed that the Zone two gap obviously increased, validating the need to test the bed in an articulated position. When the prescribed testing procedure was followed, the right rail failed the Zone two test with the head of the bed raised to approximately 30 percent as the cone passed through the gap. When the bed was in the flat position, the right rail passed the Zone two test. The RAI coordinator indicated that resident #002's bed is to be kept in the flat position when the resident is in the bed and that hourly checks of the resident while in bed were in place. It was later confirmed by the Inspector that this was documented in the resident's plan of care. The plan of care also indicated that the resident becomes restless and may attempt to get out of bed on his/her own.

The DOC and the consultant indicated that the importance of keeping resident #002's bed in the flat position would be reinforced to all nursing staff.

The RAI coordinator, the DOC, the consultant and the Inspector then proceeded to resident #003's bedroom. The RAI coordinator conducted a test of the Zone two gap on the right full rail on resident #003's bed. With the bed in the flat position, it was determined that the right rail failed Zone two, towards the end of the rail. With the head of the bed raised, the Zone two gap obviously increased, validating the need to test the bed in an articulated position. The right rail failed the Zone two test with the head of the bed raised to approximately 30 percent as the cone passed through the gap easily. The RAI coordinator indicated that resident #003's bed is to be kept in the flat position when the resident is in the bed and that hourly checks of the resident while in bed were in place. It was later confirmed by the Inspector that this was documented in the resident's plan of care.

The DOC and the consultant indicated that the importance of keeping resident #003's bed in the flat position would be reinforced to all nursing staff.

The RAI coordinator, the DOC, the consultant and the Inspector then proceeded to another bedroom, to resident #004's bed space. The left side of the bed was against the wall and there was a rotating assist rail (RAR) on either side of the bed frame. This type of rail can be used in either the up or down position. The RAI coordinator indicated that when resident #004 is in bed, the right RAR is kept down. The RAI coordinator indicated that for all bed systems with RARs, he had only tested Zone two, three and four with the RARs in the down position. As per the HC guidance document, rails are to be tested at every intermediate position, as the gaps may differ from position to position.

Discussion then progressed to the prescribed testing process for Zone four. As per the HC guidance document, the gap can change with different rail height positions and as the head or foot section of the bed is raised and lowered. The RAI coordinator acknowledged that he had some uncertainty about the testing process for Zone four. The RAI coordinator, the DOC and the consultant agreed that there was a need for the RAI coordinator to be retrained and for another person at the home to be trained on the process for evaluating bed systems in accordance with the HC guidance document.

Related to resident #002, later in the day on December 21st, 2016, the consultant advised the Inspector that several new beds were on order and that the resident would be receiving one of them as soon as they were received.

Related to resident #003, later in the day on December 21st, 2016, the home's clinical nurse, #S107, informed the Inspector and the consultant that the resident had unpredictable and uncontrolled movement when in bed. The clinical nurse informed that the resident thrashes about, and can turn herself/himself over. Such movement increases a resident's risk of entrapment when bed rails are in use. The consultant indicated that she would roll up blankets and stuff them into the space between the rails and the mattress, in an effort to mitigate the potential entrapment risk of zone two. The consultant indicated that she would be implementing documented half hour checks for resident #003 while in bed, and would also have staff sign off that the blankets were in place between the rails and the mattress. The consultant indicated that a number of new beds were on order and that resident #003 would be receiving one of them as soon as they were received. On December 22nd, 2016, the consultant informed that they had tried a different mattress on resident #003's bed frame with a different type of rail padding, yet the bed system still failed the Zone two test towards the foot of the bed when the bed was in the flat position.

Related to the RARs, On December 22nd, 2016, the Inspector observed that there were

a total of nine residents in bed systems that included the RARs, including resident #004. It was confirmed that for six of the nine residents, one or both RARs on the bed frame are in the up position when the resident is in bed.

Personal Support Worker (PSW, #S104) explained to the Inspector that for resident # 005, the left RAR stays up when the resident is in bed and the left RAR, which was against the wall, stays down. For resident #006, PSW #S104 explained that the both RARs stay up when the resident is in bed. For resident #007, PSW #104 explained that the left RAR stays up and the right RAR stays down when the resident is in bed. PSW #S104 pointed out to the Inspector that there was a pictograph on the wall behind/next to each resident's bed which showed the proper placement of the RARs when the resident was in bed. PSW #S104 explained to the Inspector that despite the pictograph on the wall for resident #006, both RARs are kept up as the resident cries if the RARs are put down. Resident #008 told the Inspector that the RARs on his/her bed are never in use when he/she is in bed, they are rotated backwards, as she/he does not wish to have them in use. Resident #009 was observed in bed, with the left RAR up and the right RAR down, which was as per the pictograph on the wall. For resident # 010, PSW #S105 explained that the resident requests both rails to be down when she is in bed. Therefore, despite the pictograph on the wall that shows one RAR up and one RAR down, they put both RARs down. Resident #011 was observed in bed with the left RAR up and the right RAR down and this was consistent with the pictograph on the wall. For resident #012, PSW #S106 confirmed that the left RAR stays up and the right RAR stays down when the resident is in bed, as per the pictograph.

Related to resident #013:

It was ascertained that resident #013's new bed system, created as a result of the removal of full rails and the addition of a new type of rail, had not been evaluated in accordance with evidence based practices at the time of the inspection.

On December 20th, 2016, the Inspector observed that resident #013 had a bed rail device on the right side of his/her bed commonly referred to as a bed helper. The rigid metal device was attached to the bed and was approximately 18 inches high, and approximately 18 inches wide, with an open space between the top and sides. In discussion with the DOC, the consultant and the RAI coordinator, the Inspector was informed that resident #013 previously had full rails on his/her bed and the bed system was deemed to have failed the entrapment zone testing. The RAI coordinator explained that following assessment of the resident, it was determined that the full bed rails could

be removed. The RAI coordinator explained that following the removal of the full rails, the resident had voiced that he/she wanted to have something to hang on to when in bed. The RAI coordinator explained that he went down to the basement, found the bed helper, and put it into use for resident #013. The RAI coordinator acknowledged that the new bed system created by the addition of the bed helper rail was not evaluated in accordance with the HC guidance document and it was agreed by all that Zone one, the space within the perimeter of the rail, would certainly fail the prescribed testing process. As per the HC guidance document, the space within the perimeter of the rail must be less than four and three quarter inches. Zone one is a potential entrapment zone for the head.

The consultant informed that a number of new beds had been ordered and that resident #013 would be provided with one as soon as they were received, with a different type of rail. The consultant informed that she had determined that resident #013 could safely transfer out of his/her bed independently, yet the resident was insistent that he/she needed something to hang on to when in the bed.

On December 21st, 2016, the bed helper was removed. The home's Clinical Nurse, #S107, explained the risk related to the bed helper to resident #013 and informed him/her that she/he would be getting a new bed with a different style of bed rail shortly. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Related to resident #001:

As previously referenced, on December 20th, 2016, it was determined that resident #001's bed system, consisting of a therapeutic air surfaces and two full bedrails, had not been evaluated in accordance with evidence based practices (HC guidance document) at the time of the inspection. As per the HC guidance document, bed systems with bed rails and therapeutic air surfaces are technically exempt from zone two, three and four testing. It is assumed that such a bed system will fail the testing due to the highly compressible nature of the surface, unless the air mattress is of a design with a firm perimeter or reinforced side walls. As a result, there is an inherent potential risk of entrapment with the use of therapeutic air surfaces and bed rails, and steps must be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. In discussion with the DOC, the RAI coordinator and the consultant on

December 20th, 2016, it was confirmed that no steps had been taken to prevent resident #001's entrapment in his/her bed system at the time of the inspection. The DOC, the RAI coordinator and the consultant indicated that they were not aware of the inherent potential risk of entrapment with the use of therapeutic air surfaces and bed rails.

The consultant indicated that the right rail on resident #001's bed system would be fixed into place that afternoon. As well, the consultant indicated that the resident would be observed and assessed while in bed over a period of days to determine if the left rail was truly necessary.

On December 21, 2016, at approximately 10:40 hours, the RAI coordinator conducted a Zone three test on the left rail of resident #001's bed system in the presence of the DOC, the consultant and the Inspector. This was done to confirm or refute the assumption that such a bed system would fail the test. Zone three is the space between the inside surface of the rail and the mattress compressed by the weight of a resident's head. The testing process as prescribed by the HC guidance document, by use of the cone only, was reviewed by the RAI coordinator prior to performing the test. The line across the flat end of the cone settled below the top surface of the therapeutic air surface once the cone was left to sink into the space by its own weight. It was therefore confirmed that Zone three failed the testing process on the left rail. The air surface did not have a firm perimeter or reinforced side walls. It was also noted that the full bed rails in use for resident #001 were the same style, on the same type of bed frame, as what was in use for resident #002 and #003. It was established on December 20th, 2016 that these bed systems failed the Zone two testing.

On the afternoon of December 21, 2016, the consultant informed the Inspector that resident #001 had been assessed and it had been determined that resident #001 did not require a therapeutic air surface. The consultant informed that the resident would be given a new mattress on December 22, 2016. The consultant indicated that she would roll up blankets and stuff them into the space between the left rail and the mattress in the meantime, in an effort to mitigate the potential entrapment risk of Zone two, three and four. As well, the consultant indicated that staff would be reminded to keep resident #001's bed in the flat position when the resident was in bed, in an effort to mitigate the potential risk of entrapment with Zone two. The consultant acknowledged that changing the mattress was not a final solution for Zone two in light of the testing results for resident #002 and #003's bed systems. [s. 15. (1) (b)]

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. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius (22°C).

On December 14, 2016, at approximately 15:30 hours, while conducting an inspection of resident bedrooms and common areas in follow up to a compliance order related to maintenance, the Inspector noted that there was no heat coming from one of the two baseboard radiator heaters (right bed space) in bedroom #A. It was set at 5 (maximum), yet was cold to the touch and the room felt cold. This was immediately reported to the acting Administrator, the Director of Care and the Maintenance Supervisor (MS, #S112). The MS observed the heater and concluded he could not rectify the problem. The acting Administrator informed that the home's heating, ventilation and air conditioning (HVAC) contractor, the Plan Group, would be called for immediate service. Similar issues were subsequently found in seven additional bedrooms. In bedroom #B, the baseboard radiator heater was set at 5 (maximum) but was only slightly warm. Resident #016 told the Inspector that he/she found it chilly in her/his room and did not think the heater went high enough. The same issue was found in bedrooms #C, #D, #E and #F. In bedrooms #G and #H, the baseboard radiator heaters were set at 5 and were cold to the touch. The acting Administrator accompanied the Inspector back to the seven additional identified bedrooms and observed the problem as well. The acting Administrator indicated that the residents in the eight affected bedrooms would be offered additional blankets for the night.

Further details and non-compliance specifically related to the malfunctioning heaters is described in part 1 of Written Notification (WN) #3 in this inspection report. The HVAC technicians with the Plan Group were onsite on December 15, 2016 for initial corrective actions.

On December 15, 2016, between 10:00 hours and 10:30 hours, the Inspector used her digital thermometer and verified the temperature in the eight affected bedrooms. The temperature was found to be below 22 °C in four of the eight bedrooms. The temperature in bedroom #A, at the armrest of resident #017's wheelchair, next to the bedside table, was at 19.4 °C It is noted that the baseboard radiator heater in resident #017's bed space (left) was functional and set to maximum, yet the heat was not sufficient to heat the bedroom in light of the malfunctioning heater on the right side of the bedroom. The resident in the right bed space of room #A was absent from the home at the time of the inspection. The temperature in bedroom #B, at the bedside table, was at 21 °C. The temperature in bedroom #D, at the bedside table, was at 20.7 °C. The temperature in bedroom #E, at the bedside table, was at 20.4 °C. With the exception of bedroom #A, it is noted that the bedroom door was partially or fully closed in the bedrooms found to be below 22 °C, as per the resident's wishes, which appeared to have prevented the heat from the hallway from supplementing the bedroom heat.

On December 15, 2016, at approximately 10:40 hours, in bedroom #E, resident #018 told the Inspector that he/she had been cold in his/her bedroom that morning. The resident explained that the night before, he/she had been offered additional blankets but he/she did not feel they were necessary as it was warm enough at the time. The resident explained that in the morning, he/she was cold when in bed and would now like to have additional blankets for use that evening. The resident explained that he/she preferred to have his/her bedroom door closed at all times and would not consider keeping it open. The resident was holding an analogue thermometer at the time of the conversation, which is typically wall mounted. The resident asked what the temperature should be at and the Inspector informed that it should be at a minimum of 22 °C. The resident noted that it was below that on his/her thermometer. The Inspector informed the resident that she had measured the temperature at the resident's bedside table earlier to be at 20.4 °C and the resident remarked that it was cold. The resident's request for additional blankets was reported to the acting Administrator.

At approximately 15:40 hours, December 15, 2016, the home's HVAC technicians (#S108 and #S109) informed the Inspector that they were in the process bleeding the malfunctioning radiators and would be ordering new thermostatic valves for them as well. They informed that they had checked all bedroom and found only one more with a malfunctioning heater, bedroom 118. They advised that the radiators should reach full capacity within 24 hours after the bleeding process, however, that the problem would recur if the valves were malfunctioning. The technicians explained that there was no way

to know for sure, as air in the system and a bad valve results in the same problem.

At approximately 16:40 hours on December 15, 2016, in bedroom #A, resident #017 told the Inspector that she/he found that it was cold in the bedroom, especially around 08:00 – 09:00 hours that morning. The resident was in their bed at the time of the conversation and told the Inspector that she/he felt cold and would like another blanket. The Inspector verified the temperature at the armrest of the resident's wheelchair, next to the bedside table, was now at 19.6 °C (vs. 19.4 °C that morning). The bedroom door was open and the heater on the right side of the bedroom was now slightly warm to the touch. The Inspector reported the resident's request for additional blankets to the acting Administrator, the Director of Care and an Extendicare Assist Nurse Consultant (#S102). It was ascertained that the resident had been provided with additional blankets the night before, but they had been removed from the room when the bed was made that morning.

An enhanced plan was put into place, including temperature monitoring in the affected bedrooms, ensuring an extra supply of blankets for both units, and leaving extra blankets in the affected bedrooms. The plan was to remain in place until such time as the baseboard radiator heaters were in good repair and the bedrooms could be maintained at a minimum temperature of 22 °C. [s. 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with the requirement that the home is maintained at a minimum temperature of 22 degrees Celsius., to be implemented voluntarily.

WN #3: 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,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented to ensure that heating, ventilation and air conditioning systems are cleaned and in a good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection.

On December 14, 2016, at approximately 15:30 hours, while conducting an inspection of resident bedrooms and common areas in follow up to a compliance order related to maintenance, the Inspector noted that there was no heat coming from one of the two baseboard radiator heaters (right bed space) in bedroom #A. It was set at 5 (maximum), yet was cold to the touch and the room felt cold. This was immediately reported to the acting Administrator, the Director of Care and the Maintenance Supervisor (MS, #S112). The MS observed the heater and concluded he could not rectify the problem. The acting Administrator informed that the home's heating, ventilation and air conditioning (HVAC) contractor, the Plan Group, would be called for immediate service. Following this, the Inspector found further issues. In bedroom #B, the baseboard radiator heater was set at 5 (maximum) but was only slightly warm. Resident #016 told the Inspector that he/she found it chilly in her/his room and did not think the heater went high enough. The same

issue was found in bedrooms #C, #D, #E, #F. In bedrooms #G and #H, the baseboard radiator heaters were set at 5 and were cold to the touch. The acting Administrator accompanied the Inspector back to the seven addition identified bedrooms and observed the problem as well. The acting Administrator indicated that the residents in the eight affected bedrooms would be offered additional blankets for the night.

Further details and non-compliance specifically regarding air temperatures related to the malfunctioning heaters in four of the eight affected bedrooms is described in Written Notification (WN) #2 in this inspection report.

On December 14th, 2016, at approximately 18:00 hours, an HVAC technician with Plan Group arrived on site (#S108). The technician was informed by the acting Administrator that there was eight affected bedrooms. The technician explained that he had been told that there was only one affected bedroom, and that he did not have time to go to all eight bedrooms. The technician informed that he would return to the home the following morning with another HVAC technician to investigate the problem.

It was confirmed by the HVAC technician that the Plan Group had conducted a maintenance inspection and service of components of the HVAC system in the Fall of 2016. The technician confirmed that the baseboard radiator heaters in resident bedrooms were not a part of this service as they were not included in the maintenance contract. As well, the technician informed that the roof top make up air units were specifically excluded from the maintenance contract.

At approximately 13:10 hours on December 15, 2016, in the company of the acting Administrator, the home's Maintenance Supervisor informed the Inspector that he does not have a process in place for preventative maintenance of the baseboard radiator heaters in resident bedrooms. He explained that he would check a heater only as a result of a complaint.

At approximately 15:40 hours on December 15, 2016, the home's HVAC technicians (#S108 and #S109) informed the Inspector that they were in the process bleeding the malfunctioning radiators and would be ordering new thermostatic valves for them as well. They informed that they had checked all bedrooms and found only one more with a malfunctioning heater, bedroom 118. They advised that the radiators should reach full capacity within 24 hours after the bleeding process, however, that the problem would recur if the valves were malfunctioning. The technicians explained that there was no way to know for sure, as air in the system and a bad valve results in the same problem.

On December 16, 2016, the Inspector was informed by the Maintenance Supervisor that another HVAC company, Optimum Heating and Cooling, provides maintenance service for the home's roof top make up air units. He informed that the roof top units were serviced in the Fall of 2016. He confirmed that Optimum Heating and Cooling did not inspect the baseboard radiator heaters in the resident bedrooms during the fall maintenance service.

On January 16th, 2017, an Environmental Services Consultant with Extendicare provided the Inspector with policy #MN-02-01-01 (last updated October 2016) and related procedures, regarding the Preventative Maintenance program. The policy indicates that homes shall have a preventive maintenance program that provides a scheduled system of routine inspections and maintenance of the building's major systems, including the building heating, ventilation and air-conditioning equipment and systems. The Administrator is to ensure the program is in place. Related to the HVAC system, the Maintenance Manager is to develop a program to provide preventative maintenance to HVAC equipment and systems, manage the program, monitor that the program is followed, and ensure that the preventive maintenance is being documented, and records kept. Procedure # 2180 relates to hot water heating systems. The procedure specifies monthly, quarterly, semi-annual and annual maintenance requirements.

Despite policy #MN 02-01-01, there was no preventative maintenance program in place with regards to the baseboard radiator heaters in resident bedrooms. The licensee has failed to ensure that procedures are implemented to ensure that heating, ventilation and air conditioning systems are cleaned and in a good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection. [s. 90. (2) (c)]

2. The licensee has failed to ensure that procedures are implemented to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius (49 °C).

On December 16th, 2016, the Inspector reviewed the water temperature log sheets for November and December 2016. This was as a result of a complaint brought forward to the Inspector by resident #008 about water temperatures. The log sheets were located on a clipboard within the South nurses' station, and were in part illegible as half of the temperatures were recorded in columns with multiple lines through them. In the columns that were clear, it was noted that temperatures in excess of 49 °C were documented on

12 of 30 evening shifts in November 2016. In December 2016, it was noted that temperatures in excess of 49 °C were documented on seven of 15 evening shifts, most recently December 13th (room #I, 54 °C), December 14 (room #J, 56.9 °C) and December 15th (room #K, 59 °C). At the bottom right side of the log sheet, there was a section that read "notify maintenance/administrator if temperature is not between 40 – 49 degrees Celsius. Put note in maintenance log book". The Inspector reviewed the maintenance log book and did not find any notations related to the elevated water temperatures.

The Inspector then spoke with the Maintenance Supervisor (MS, #S112) who confirmed that he had never been informed of a water temperature in excess of 49 °C. The MS explained that his sole involvement with water temperatures was his report to the day nurse to inform what the boiler temperature is at so that it can be recorded on the log sheet.

The Inspector, the Director of Care, the Clinical Nurse (#S107) an Extendicare Assist Nurse Consultant (#S102) compared the Inspector's digital thermometer with the digital thermometer that registered nursing staff were using to monitor water temperatures. The thermometers were found to be registering the temperature at the same level, differing only by 0.1 to 0.2 degrees Celsius at some points during the observation period.

It was ascertained that Registered Nurse (RN, #S110) had documented the three most recent elevated evening water temperatures for December 2016. The Inspector met with RN #S110 at approximately 15:05 hours on December 16th, 2016 and asked if she had reported the elevated water temperatures to the MS, or to the Administrator, or taken any other action in response to the elevated water temperatures. RN #S110 indicated that she had not reported the elevated water temperatures to anyone and had not taken any other action in response. RN #S110 told the inspector that residents are typically in bed when she takes the water temperatures and therefore she did not feel there was risk of the residents accessing the hot water.

The Inspector was provided with the home's "water temperature" policy (ADMI-04-04-10, implementation date of January, 2006) by an Extendicare Assist Nurse Consultant (#S102). In response to any water temperature greater than 49 °C, the staff procedure is to: immediately report to the maintenance person while on duty or in his/her absence to management on call; immediately inform all nursing staff so they are aware and residents can be monitored; charge nurse is to alert the Support Services Supervisor while on duty or the manager on call during non-business hours and weekends;

Maintenance/Administration to notify Charge nurse when the water temperature has been returned to the normal range; Charge nurse will subsequently notify the nursing units that is safe to resume use of hot water; Charge Nurse is to document corrective action taken on the back of the water temperature log; the Administrator/Designate will monitor the record of temperatures minimally on a monthly basis, sign the record and retain the log as per health care record policy, ensure that the log for the current month is available in the binder and ensure that logs for all previous months are removed, filed and stored.

Despite policy #ADMI-04-04-10, immediate action was not taken to reduce water temperatures when they were known to have exceeded 49 °C. The licensee has failed to ensure that procedures are implemented to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius. [s. 90. (2) (h)]

3. The licensee has failed to ensure that procedures are developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius (°C).

On December 15th, 2016, resident #008 informed the Inspector that the bathtub water temperature dial in the South spa room did not appear to be working properly. The resident explained that while supervised and assisted by staff, he/she uses the bath tub shower wand, while sitting in the bath tub, to bathe herself/himself. The resident explained that that morning during his/her tub shower, when the temperature control dial was at cold, the water was lukewarm and then when the dial was at hot, the water was cold. The resident indicated that this had been going on for at least three months, but that morning was the worst it had ever been. The resident informed that is was Personal Support Worker (PSW, #S101) who had been with her/him during his/her tub shower that morning. The Inspector then spoke with PSW #S101 who confirmed that the water temperature had fluctuated that morning, stating it was warm then cold, warm, then cold. PSW #S101 indicated that it had been awhile since this type of thing has been going on, and confirmed that she had not reported the issue to the Maintenance Supervisor (MS, #S112) or noted it in the maintenance book.

At approximately 16:00 hours, the Inspector spoke with PSW #S104 outside of the South tub room. The PSW informed that she had given a shower to a resident that afternoon and the water was either too hot or too cold, it would not stay stable. The PSW indicated that she had not yet reported the issue but would do so.

On December 16th, 2016, the Inspector verified the bathtub water temperature in the South spa room starting at 11:40 hours. The dial was set at 20, the lowest setting, and the water temperature fluctuated within the range of 39.3 °C and 40.8 °C for four minutes. At 11:44 hours, the dial was then turned up to the next setting, 30. The fluctuating temperatures were recorded every minute up until 11:53 hours and were as follows: 37 °C, 35 °C, 32 °C, 39.6 °C, 43.2 °C, 35.2 °C, 33.9 °C, 36.9 °C, and 40 °C. At 11:53 hours the dial was then turned up to the next setting, 38. The fluctuating temperature was recorded every minute up until 11:57 hours and were as follows: 39.3 °C, 34.7 °C, 36.2 °C, and 39.6 °C. During this testing period, the water could not be maintained at a temperature of at least 40 °C when the dial was set at 30 and at 38.

At approximately 14:10 hours, the Inspector spoke with the MS who advised that he had not been aware of the fluctuating water temperatures. The MS informed that it had been reported to him that day, by an outside contractor, that the mixing valve between the hot and cold water supply was leaking and required replacement. He explained that as a result, water temperatures throughout the home would be going up and down. As well, the MS informed that the home's hot water tank required replacement. He indicated that the contractor would be replacing the hot water tank and the mixing valve the following week.

On January 26th, 2017, an Extendicare Nurse Consultant, (the consultant, #S102), confirmed that at the time of the on-site inspection, the home's Registered Nurses had the responsibility for regular monitoring of water temperatures in the spa rooms. The consultant advised that this occurred at minimum twice a week. The consultant provided the Inspector with the Extendicare "Water Temperature" policy (implementation date of January 2016) #ADMI-04-04-10 as representative of the procedure in place to ensure that the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius (°C).

The procedure in place, whereby Registered Nurses monitored the water temperature in the spa rooms at minimum twice a week, did not ensure that the temperature of the hot water serving the bathtub in the South spa room was maintained at a temperature of at least 40 degrees Celsius (°C). [s. 90. (2) (i)]

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 components of the heating, ventilation and air conditioning system (HVAC) are cleaned, in a good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; and, to ensure that the temperature of the hot water serving all bathtubs and showers used by residents can be maintained at a temperature of at least 40 degrees Celsius.

The plan is to include review of maintenance contracts and agreements in place to ensure that all components of the home's HVAC system are scheduled for inspection at least every six months by a certified individual. The plan is to include measures to ensure the full implementation of the licensee's policy related to maintenance of the HVAC system, #MN 02-01-01, and all related preventative maintenance procedures for the HVAC system. The Administrator or Designate will ensure the program is in place, as per the policy.

The plan is to include a process whereby the the licensee's policy related to water temperature monitoring, #ADMI-04-04-10, is reviewed by all of the home's staff involved in it's implementation. The plan is to provide for the monitoring of the record of temperatures minimally on a monthly basis by the Administrator or Designate, as per the policy. The plan is to include a strategy that will ensure the provision of water below 49 degrees Celsius to all bathtubs, showers and hand basins used by residents, at all times, as is required by O. Reg. 79/10, s. 90 (2) (g).

The plan is to include a process whereby the cause for the water temperature fluctuations observed in the South tub room bathtub is determined, if the home's malfunctioning mixing valve was not the cause. The plan is to include a process to ensure that the home's bathtubs are kept in good repair and are maintained at a level that meets manufacturer specifications, as is required by O. Reg. 79/10, s. 90 (2) (a). The plan is to include a strategy that provides for follow up review of tubroom water temperature monitoring log sheets by management staff.

The plan is, to be implemented voluntarily.

Issued on this 27th day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2016_346133_0042
Log No. / Registre no:	020620-16, 026727-16, 029174-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 27, 2017
Licensee / Titulaire de permis :	CVH (No.4) GP Inc. as general partner of CVH (No.4) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes Inc., CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	MANOIR MAROCHEL 949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sharon Gilmour

To CVH (No.4) GP Inc. as general partner of CVH (No.4) LP, 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)

Linked to Existing Order / Lien vers ordre existant: 2016_286547_0019, CO #001;

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 is ordered to do the following:

1. Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment. The risk interventions identified in the Health Canada guidance document companion document, "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment (US. FDA, June 2006), shall be considered for each resident and their bed system, including any bed system with a therapeutic air mattress. This will be done using an individualized, systematic and documented approach. These actions must be completed within seven days of this order being served.

2. All bed systems where bed rails are used in the home shall be re-evaluated by a service provider with demonstrated experience and expertise in the evaluation of bed systems in accordance with the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail latching Reliability and Other Hazards, 2008" (HC guidance document). This is to include the evaluation of rotating assist rails in both the up and down positions. The re-evaluation is to be documented and dated, and it shall be

specified if the bed system was flat or articulated when Zone two was tested. This must be completed within 14 days of this order being served.

3. Develop and implement a written process for ensuring that all future bed system failures, including failures identified as a result of the re-evaluation of bed systems as ordered, are addressed immediately by taking the necessary corrective actions in accordance with the HC guidance document companion document titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment (US. FDA, June 2006). Ensure that when any modification is made to a bed system with bed rails in use (such as a change of mattress, use of therapeutic surfaces, a new type of bed rail is put into place, or an accessory is added), the resulting new bed system is evaluated in accordance with evidence based practices (HC guidance document) in order to minimize risk to the resident. The evaluation is to be conducted prior to the bed system being used by the resident, and must be documented and dated.

4. Retraining on the evaluation of bed systems with bed rails in use shall be provided to the RAI coordinator by a service provider with demonstrated experience and expertise in the evaluation of bed systems in accordance with the HC guidance document. Training is to be provided to any other staff person in the home that will conduct bed system evaluations. The training/retraining is to be confirmed in writing.

5. Develop an ongoing method to document the current location of every bed system with bed rails in use that includes consistent identifying information for the bed system components (i.e. bed frame type and #, mattress type and #, bed rail type), the date and results of the latest bed system evaluation, including all of the potential Zones of entrapment and any corrective actions taken as a result of the evaluation.

6. Develop and implement a written policy to ensure that an interdisciplinary team (the team) assesses all residents in the home with bed rails in use, in accordance with the prevailing practices outlined in "Clinical Guidance for the Assessment and Implementation of Bed rails in Hospitals, Long Term Care Homes, and Home Care settings (US FDA, April 2003), a companion document to the HC guidance document. The policy will ensure that the decision to keep bed rails in use must be approved by the team, and, that the team will ensure that all residents hereafter are assessed before the decision to use or discontinue the use of a bed rail is made. The policy will ensure that all residents

with bed rails in use are reassessed by the team, at a minimum, whenever there is a change in the resident's physical condition as recommended in the HC guidance document. The policy will ensure that the names of the team members who participate in the assessment, the final results of the assessment, including the risk-benefit analysis, and ensuing recommendations are documented within the resident's health care record if not within the "bedrail and entrapment risk assessment"

7. Update the written plan of care based on the resident assessment by the interdisciplinary team for all residents where bed rails are used. Include any necessary accessories or interventions that are required to mitigate any identified bed safety hazards. Include all required information as specified in the FDA 2003 clinical guidance document, such as related to the use of bed rails for a medical symptom or condition vs. bed rails used for a resident's mobility and/or transferring.

Grounds / Motifs :

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

The licensee has a history of non-compliance with O. Reg. 79/10, s. 15 (1). As a result of the Resident Quality Inspection conducted in July and August 2016, #2016_286547_0019, the licensee was served with a compliance order. As a result of the Resident Quality Inspection conducted in December 2015, # 2015_286547_0025, a Written Notification was issued. The non-compliance presented below is widespread and presents potential risk to all residents with bed rails in use. As a result of the compliance history, scope of non-compliance and severity of non-compliance, a compliance order will be served to the licensee.

In August 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes,

where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones one -seven), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones one - four), and prescribes test tools (cone and cylinder tool with spring scale) and methods to measure and assess gaps in some of the potential entrapment zones (Zones one - four).

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

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003) (FDA 2003 clinical guidance document). This document provides necessary guidance in establishing a clinical assessment where bed rails are used and directs that the automatic use of bed rails is to be avoided as this may pose unwarranted hazards to resident safety. In this document, it is indicated that any decision to use or discontinue the use of bed rails should be made within the context of an individualized resident assessment using an interdisciplinary team. The individual assessment is to include numerous factors including the resident's medical needs, sleep habits, and mobility (in and out of the bed). The sleeping environment assessment includes elements or conditions that may affect the resident's ability to sleep, such as comfort, appropriate bed and medical stabilization. The decision to use bed rails should include a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. If clinical and environmental interventions have proven unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of interventions or of not using them, bed rails may be used. Documentation of the risk-benefit assessment should be in the resident's health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly. The document directs that bed rail use should be accompanied by a care plan (treatment program) and information to be included in the care plan is specified, including clear direction for further investigation of

less restrictive care interventions if the bed rail use is for treatment of a medical symptom or condition, and options for reducing the risk of rail use and education for the resident about possible bed rail danger if the bed rail use is for resident mobility and/or transferring.

Related to resident #001:

It was ascertained that at the time of the inspection, the resident was not assessed in accordance with prevailing practices, nor was his/her bed system evaluated in accordance with evidence based practices, to minimize risk to the resident.

As observed by the Inspector on December 20th, 2016 at 10:00 hours, resident #001's bed system included a therapeutic air mattress (ZephAire therapeutic support surface) and two functional full length bed rails on the bed frame. A Personal Support Worker (PSW, #S101) informed the Inspector that the left rail was always kept in the up position when resident #001 was in bed, and the right rail was raised to assist with positioning during the provision of care. The left rail was covered by a bumper pad and the right rail was bare at the time of observation.

On December 20th, 2016, the Inspector met with the Director of Care (DOC), an Extendicare Assist Nurse Consultant (the consultant, #S102) and the RAI coordinator to discuss corrective actions taken as a result of the Compliance Order served to the licensee as a result of inspection #2016_286547_0019. The Inspector was informed that all residents had been assessed with regards to bed rail use and all bed systems had been evaluated, in advance of the compliance date of September 16th, 2016. The Inspector inquired specifically about resident #001, in light of the full rails and therapeutic air surface in use. The Inspector was informed that resident #001 was recently admitted to the home. The DOC explained that in advance of resident #001's admission, on November 28, 2016, she went to the basement, found a functional air mattress and directed it be put into use for resident #001 as per her understanding of the resident's clinical needs. The DOC confirmed that she did not fill out a "bed/mattress change form", which the home implemented as a result of the Compliance Order, to track bed moves or changes and to initiate bed system evaluations. The DOC explained that she later learned that there had been no bed frame in the bed space designated for resident #001 when she directed that the air mattress be put into use. A bed frame with full bed rails that had also been down

in the basement was put into use with the air mattress for resident #001. It could not be determined who had decided to put that particular frame with full rails into use for resident #001. The RAI coordinator indicated that he was on vacation at the time of resident #001's admission. The RAI coordinator was the only person trained to evaluated bed systems at the home at that time and at the time of the inspection. The RAI coordinator confirmed that he did not evaluated the bed system in place for resident #001 upon his return from vacation. The RAI coordinator indicated that he was unsure why he did not evaluate the bed system, and speculated that perhaps it was because it was an air mattress. As per the HC guidance document, bed systems with bed rails and therapeutic air surfaces are technically exempt from Zone two, three and four testing. It is assumed that such a bed system will fail the testing due to the highly compressible nature of the surface, unless the air mattress is of a design with a firm perimeter or reinforced side walls. As per the HC guidance document, bed systems using therapeutic air surfaces are not exempt from zone one (the space between the rails) testing. As well, the technical exemption does not preclude the evaluation of Zone six, the space between the end of the rail and the side edge of the headboard or footboard or of Zone 7, the space between the inside surface of the headboard or footboard and the end of the mattress.

The RAI coordinator provided the Inspector with the resident #001's "bed rail and entrapment risk assessment". It was noted that the assessment was initiated the day following the resident's admission to the home, on November 29th, 2016. The assessment identified that resident #001 was at risk of bed entrapment (section B1) due to seven selected items (section A) that could contribute to the resident's individualized risk for bed entrapment. The RAI coordinator explained that the bed rail and entrapment risk assessment was mandatory for the admission process for all new residents. The RAI coordinator explained that the assessment had been initiated by Registered Nurse #S102 and that he (the RAI coordinator) had locked it, without making any changes or additions to it, on December 20th, 2016. The assessment made no reference to the use of bed rails for resident #001. The resident was not assessed using an interdisciplinary team, nor was the decision to use bed rails for resident #001 approved by an interdisciplinary team. The RAI coordinator agreed that the assessment did not demonstrate any rationale for use of bed rails for resident #001. The RAI coordinator provided the Inspector with resident #001's plan of care. The plan of care did not reference use of bed rails for resident #001.

The consultant indicated that the right rail on resident #001's bed system would

be fixed into place that afternoon. As well, the consultant indicated that the resident would be observed and assessed while in bed over a period of days to determine if the left rail was truly necessary. The Inspector was informed that the resident was known to move his/her arms while in bed but not to move his/her body while in bed.

Related to the assessment of residents for bed rail use in accordance with prevailing practices:

A process for assessing residents for bed rail use was implemented in response to the Compliance Order served to the licensee as a result of inspection #2016_286547_0019. It was ascertained that the process in place was not in accordance with prevailing practices (FDA 2003 clinical guidance document).

On December 20th, 2016, in discussion with the DOC, the consultant and the RAI coordinator, the RAI coordinator indicated that he had done the majority of the resident assessments, with the "Bedrail and Entrapment Risk Assessment". The RAI coordinator explained that he was well acquainted with the existing residents' sleep habits, mobility in bed and comfort while in bed, and felt he could answer the related questions accurately. The RAI coordinator acknowledged that for new residents, such as resident #001, staff are not well acquainted with such factors. The RAI coordinator, the DOC and the consultant noted that the assessment process does not direct staff to observe the resident while in bed, and therefore it could be difficult for staff to accurately answer questions about a new residents' sleep habits, mobility in bed and comfort while in bed. As well, it was noted that there was no process in place to conduct individualized resident assessments by an interdisciplinary team, or to have the decision to use bed rails approved by an interdisciplinary team, as per the FDA 2003 clinical guidance document.

On December 22nd, 2016, the RAI coordinator acknowledged a lack of clarity with regards to certain aspects of the "Bedrail and Entrapment Risk Assessment" questions.

Part B of the assessment is about building the plan of care based on the risk assessment conducted in Part A. The first question in Part B asks "Is the Resident at risk for bed entrapment?". Looking at resident #015 vs. resident #013's assessment, resident #015 had nine items selected, in Part A, that would

contribute to the resident's individualized risk for bed entrapment, yet it was indicated she/he was not at risk of bed entrapment. Resident #013 had two items selected in Part A, yet it was indicated that she/he was at risk of bed entrapment. The RAI coordinator explained that resident #015 was in a high low bed with a type of rail that had passed the entrapment zone testing, so he did not feel he/she was at risk of entrapment, despite all of the identified risk factors in Part A. The RAI coordinator explained that resident #013 was in a bed with full rails that failed the entrapment testing at the time of the assessment, so he felt she/he was at risk of entrapment. It was noted that when the question was answered with a Yes, direction related to referrals to appropriate disciplines or teams to determine alternatives to bed rails, and planning for a safe bed system were generated. The risk assessment conducted in Part A was not considered by the RAI coordinator when answering the question, only the results of the bed system evaluations. The risk assessment in Part A does not reference bed system evaluations, it is exclusively related to the resident. As discussed with the RAI coordinator, entrapments may occur despite the fact that a potential zone of entrapment has been deemed to pass the prescribed entrapment zone testing. As well, as per the 2003 FDA clinical guidance document, residents are to be assessed prior to the implementation of bed rail use.

The second question in Part B asks "Is the resident independent for bed mobility AND has not had a previous fall from bed AND is able to effectively call for assistance when in bed?". This question further probes for the resident's risk of entrapment. Looking at resident #014's (referenced as resident # 039 in the Compliance Order issued as a result of inspection #2016_286547_0019) assessment, the RAI coordinator had answered "Yes" to the question. The Inspector was aware that resident #014 was not able to effectively call for assistance when in bed. The question should have been answered with a "No". The RAI coordinator explained that he would answer "Yes" to the first two parts of the question and "No" to the last part. The RAI coordinator explained as there were more "Yes" than "No", he answered "Yes" to the overall question. As a result, the next question in the assessment was related to the resident's independence through the use of bed rails for positioning. When the RAI coordinator changed the answer to a "No", the next question was then about planning for a safe bed system.

The RAI coordinator indicated that he would seek retraining on the use of the "Bedrail and Entrapment Risk Assessment".

Related to the evaluation of all bed systems in the home with bed rails in use in accordance with evidence-based practices:

A process for evaluating bed systems was implemented in response to the Compliance Order served to the licensee as a result of inspection #2016_286547_0019. It was ascertained that the process in place was not in accordance with evidenced-based practices (HC guidance document)

It was ascertained that none of the 21 bed systems with bed rails in use had been evaluated in accordance with the HC guidance document. The bed systems had not been correctly evaluated with regards to Zone two. Zone two is the gap under the rail between a mattress compressed by the weight of a head and the bottom edge of the rail at a location between the rail supports, or next to a single rail support. Furthermore, it was ascertained that the nine bed systems with rotating assist rails had also been incorrectly evaluated with regards to Zone three and Zone four. Zone three is the space between the inside surface of the rail and the mattress compressed by the weight of a resident's head. Zone four is the gap that forms between the mattress compressed by the resident and the lowermost portion of the rail, at the end of the rail. The space poses a risk of entrapment of a resident's neck.

On December 20, 2016, the Inspector worked with the DOC and the consultant to review documentation related to past and current bed system evaluations. It was noted that in the past, the bed system in use for resident #002 and resident #003, with full bed rails, had failed Zone two testing. The Inspector was informed that full length rail pads had been applied as corrective action. It was noted that the two bed systems had since been re-evaluated by the RAI coordinator, and were deemed to have passed the Zone two testing process. As rail pads do not affect the Zone two gap, it was unclear to the Inspector how this intervention could have affected the Zone two test results

As per the HC guidance document, the Zone two test is the only test not always done with the bed in the flat position. The test assesses the potential for head entrapment under the rail. Before the test is done, the correct testing position must be found. With the bed in the flat position, the Zone two space is located. Then, the bed is to be articulated (adjusting the head and knee sections) while the Zone two space is observed. As the bed is articulated, the Zone two space may get bigger, smaller, or stay the same. The position is to be adjusted until the position which makes the largest opening in zone two is found. If the size of the

opening gets smaller, or does not change, the bed is to be returned to the flat position to do the test. Once the proper position is found, the test is to be done with the cone (independent of the cylinder attachment) and the spring scale. The safety strap is to be used to secure the cone to the rail being tested, the cone is then inserted, small end first, into the gap between the mattress and the lower edged of the rail, between the rail supports. The cone must be allowed to compress the mattress. Then, the spring scale is to be attached to the loop on the cone. The spring scale is to pulled using 12 lbs of force at any angle that increases the chances of the cone going through the space. If the large end of the cone enters the space under the rail, or passes under the rail, this space fails the test.

On December 21, 2016, the Inspector requested that the home's RAI coordinator demonstrate the process that he had used to test Zone two on resident #002's bed system. In the presence of the Inspector, the DOC and the consultant, the RAI coordinator demonstrated that he used the cone with the cylinder to do the test for Zone two. He held the end of the cylinder in his hand and the small end of the cone was positioned in the space between the right rail and the mattress on resident #002's bed. The cone did not go down into the space. The RAI coordinator concluded that Zone two had passed the test.

The RAI coordinator confirmed that he had done all Zone two tests with the cone attached to the cylinder, and without the use of the spring scale. As well, the RAI coordinator confirmed that he had always done Zone two tests with the bed in the flat position.

The testing process for Zone two, as per the HC guidance document, was then reviewed. The RAI coordinator raised the head of resident #002's bed and it was observed that the Zone two gap obviously increased, validating the need to test the bed in an articulated position. When the prescribed testing procedure was followed, the right rail failed the Zone two test with the head of the bed raised to approximately 30 percent as the cone passed through the gap. When the bed was in the flat position, the right rail passed the Zone two test. The RAI coordinator indicated that resident #002's bed is to be kept in the flat position when the resident is in the bed and that hourly checks of the resident while in bed were in place. It was later confirmed by the Inspector that this was documented in the resident's plan of care. The plan of care also indicated that the resident becomes restless and may attempt to get out of bed on his/her own.

The DOC and the consultant indicated that the importance of keeping resident #002's bed in the flat position would be reinforced to all nursing staff.

The RAI coordinator, the DOC, the consultant and the Inspector then proceeded to resident #003's bedroom. The RAI coordinator conducted a test of the Zone two gap on the right full rail on resident #003's bed. With the bed in the flat position, it was determined that the right rail failed Zone two, towards the end of the rail. With the head of the bed raised, the Zone two gap obviously increased, validating the need to test the bed in an articulated position. The right rail failed the Zone two test with the head of the bed raised to approximately 30 percent as the cone passed through the gap easily. The RAI coordinator indicated that resident #003's bed is to be kept in the flat position when the resident is in the bed and that hourly checks of the resident while in bed were in place. It was later confirmed by the Inspector that this was documented in the resident's plan of care.

The DOC and the consultant indicated that the importance of keeping resident #003's bed in the flat position would be reinforced to all nursing staff.

The RAI coordinator, the DOC, the consultant and the Inspector then proceeded to another bedroom, to resident #004's bed space. The left side of the bed was against the wall and there was a rotating assist rail (RAR) on either side of the bed frame. This type of rail can be used in either the up or down position. The RAI coordinator indicated that when resident #004 is in bed, the right RAR is kept down. The RAI coordinator indicated that for all bed systems with RARs, he had only tested Zone two, three and four with the RARs in the down position. As per the HC guidance document, rails are to be tested at every intermediate position, as the gaps may differ from position to position.

Discussion then progressed to the prescribed testing process for Zone four. As per the HC guidance document, the gap can change with different rail height positions and as the head or foot section of the bed is raised and lowered. The RAI coordinator acknowledged that he had some uncertainty about the testing process for Zone four. The RAI coordinator, the DOC and the consultant agreed that there was a need for the RAI coordinator to be retrained and for another person at the home to be trained on the process for evaluating bed systems in accordance with the HC guidance document.

Related to resident #002, later in the day on December 21st, 2016, the

consultant advised the Inspector that several new beds were on order and that the resident would be receiving one of them as soon as they were received.

Related to resident #003, later in the day on December 21st, 2016, the home's clinical nurse, #S107, informed the Inspector and the consultant that the resident had unpredictable and uncontrolled movement when in bed. The clinical nurse informed that the resident thrashes about, and can turn herself/himself over. Such movement increases a resident's risk of entrapment when bed rails are in use. The consultant indicated that she would roll up blankets and stuff them into the space between the rails and the mattress, in an effort to mitigate the potential entrapment risk of zone two. The consultant indicated that she would be implementing documented half hour checks for resident #003 while in bed, and would also have staff sign off that the blankets were in place between the rails and the mattress. The consultant indicated that a number of new beds were on order and that resident #003 would be receiving one of them as soon as they were received. On December 22nd, 2016, the consultant informed that they had tried a different mattress on resident #003's bed frame with a different type of rail padding, yet the bed system still failed the Zone two test towards the foot of the bed when the bed was in the flat position.

Related to the RARs, On December 22nd, 2016, the Inspector observed that there were a total of nine residents in bed systems that included the RARs, including resident #004. It was confirmed that for six of the nine residents, one or both RARs on the bed frame are in the up position when the resident is in bed.

Personal Support Worker (PSW, #S104) explained to the Inspector that for resident # 005, the left RAR stays up when the resident is in bed and the left RAR, which was against the wall, stays down. For resident #006, PSW #S104 explained that the both RARs stay up when the resident is in bed. For resident #007, PSW #104 explained that the left RAR stays up and the right RAR stays down when the resident is in bed. PSW #S104 pointed out to the Inspector that there was a pictograph on the wall behind/next to each resident's bed which showed the proper placement of the RARs when the resident was in bed. PSW #S104 explained to the Inspector that despite the pictograph on the wall for resident #006, both RARs are kept up as the resident cries if the RARs are put down. Resident #008 told the Inspector that the RARs on his/her bed are never in use when he/she is in bed, they are rotated backwards, as she/he does not wish to have them in use. Resident #009 was observed in bed, with the left RAR

up and the right RAR down, which was as per the pictograph on the wall. For resident # 010, PSW #S105 explained that the resident requests both rails to be down when she is in bed. Therefore, despite the pictograph on the wall that shows one RAR up and one RAR down, they put both RARs down. Resident #011 was observed in bed with the left RAR up and the right RAR down and this was consistent with the pictograph on the wall. For resident #012, PSW #S106 confirmed that the left RAR stays up and the right RAR stays down when the resident is in bed, as per the pictograph.

Related to resident #013:

It was ascertained that resident #013's new bed system, created as a result of the removal of full rails and the addition of a new type of rail, had not been evaluated in accordance with evidence based practices at the time of the inspection.

On December 20th, 2016, the Inspector observed that resident #013 had a bed rail device on the right side of his/her bed commonly referred to as a bed helper. The rigid metal device was attached to the bed and was approximately 18 inches high, and approximately 18 inches wide, with an open space between the top and sides. In discussion with the DOC, the consultant and the RAI coordinator, the Inspector was informed that resident #013 previously had full rails on his/her bed and the bed system was deemed to have failed the entrapment zone testing. The RAI coordinator explained that following assessment of the resident, it was determined that the full bed rails could be removed. The RAI coordinator explained that following the removal of the full rails, the resident had voiced that he/she wanted to have something to hang on to when in bed. The RAI coordinator explained that he went down to the basement, found the bed helper, and put it into use for resident #013. The RAI coordinator acknowledged that the new bed system created by the addition of the bed helper rail was not evaluated in accordance with the HC guidance document and it was agreed by all that Zone one, the space within the perimeter of the rail, would certainly fail the prescribed testing process. As per the HC guidance document, the space within the perimeter of the rail must be less than four and three quarter inches. Zone one is a potential entrapment zone for the head.

The consultant informed that a number of new beds had been ordered and that resident #013 would be provided with one as soon as they were received, with a

different type of rail. The consultant informed that she had determined that resident #013 could safely transfer out of his/her bed independently, yet the resident was insistent that he/she needed something to hang on to when in the bed.

On December 21st, 2016, the bed helper was removed. The home's Clinical Nurse, #S107, explained the risk related to the bed helper to resident #013 and informed him/her that she/he would be getting a new bed with a different style of bed rail shortly. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Related to resident #001:

As previously referenced, on December 20th, 2016, it was determined that resident #001's bed system, consisting of a therapeutic air surfaces and two full bedrails, had not been evaluated in accordance with evidence based practices (HC guidance document) at the time of the inspection. As per the HC guidance document, bed systems with bed rails and therapeutic air surfaces are technically exempt from zone two, three and four testing. It is assumed that such a bed system will fail the testing due to the highly compressible nature of the surface, unless the air mattress is of a design with a firm perimeter or reinforced side walls. As a result, there is an inherent potential risk of entrapment with the use of therapeutic air surfaces and bed rails, and steps must be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. In discussion with the DOC, the RAI coordinator and the consultant on December 20th, 2016, it was confirmed that no steps had been taken to prevent resident #001's entrapment in his/her bed system at the time of the inspection. The DOC, the RAI coordinator and the consultant indicated that they were not aware of the inherent potential risk of entrapment with the use of therapeutic air surfaces and bed rails.

The consultant indicated that the right rail on resident #001's bed system would be fixed into place that afternoon. As well, the consultant indicated that the resident would be observed and assessed while in bed over a period of days to determine if the left rail was truly necessary.

On December 21, 2016, at approximately 10:40 hours, the RAI coordinator conducted a Zone three test on the left rail of resident #001's bed system in the presence of the DOC, the consultant and the Inspector. This was done to confirm or refute the assumption that such a bed system would fail the test. Zone three is the space between the inside surface of the rail and the mattress compressed by the weight of a resident's head. The testing process as prescribed by the HC guidance document, by use of the cone only, was reviewed by the RAI coordinator prior to performing the test. The line across the flat end of the cone settled below the top surface of the therapeutic air surface once the cone was left to sink into the space by its own weight. It was therefore confirmed that Zone three failed the testing process on the left rail. The air surface did not have a firm perimeter or reinforced side walls. It was also noted that the full bed rails in use for resident #001 were the same style, on the same type of bed frame, as what was in use for resident #002 and #003. It was established on December 20th, 2016 that these bed systems failed the Zone two testing.

On the afternoon of December 21, 2016, the consultant informed the Inspector that resident #001 had been assessed and it had been determined that resident #001 did not require a therapeutic air surface. The consultant informed that the resident would be given a new mattress on December 22, 2016. The consultant indicated that she would roll up blankets and stuff them into the space between the left rail and the mattress in the meantime, in an effort to mitigate the potential entrapment risk of Zone two, three and four. As well, the consultant indicated that staff would be reminded to keep resident #001's bed in the flat position when the resident was in bed, in an effort to mitigate the potential risk of entrapment with Zone two. The consultant acknowledged that changing the mattress was not a final solution for Zone two in light of the testing results for resident #002 and #003's bed systems. [s. 15. (1) (b)]

(133)

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential

zones of entrapment.

Related to resident #001:

As previously referenced, on December 20th, 2016, it was determined that resident #001's bed system, consisting of a therapeutic air surfaces and two full bedrails, had not been evaluated in accordance with evidence based practices (HC guidance document) at the time of the inspection. As per the HC guidance document, bed systems with bed rails and therapeutic air surfaces are technically exempt from zone two, three and four testing. It is assumed that such a bed system will fail the testing due to the highly compressible nature of the surface, unless the air mattress is of a design with a firm perimeter or reinforced side walls. As a result, there is an inherent potential risk of entrapment with the use of therapeutic air surfaces and bed rails, and steps must be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. In discussion with the DOC, the RAI coordinator and the consultant on December 20th, 2016, it was confirmed that no steps had been taken to prevent resident #001's entrapment in his/her bed system at the time of the inspection. The DOC, the RAI coordinator and the consultant indicated that they were not aware of the inherent potential risk of entrapment with the use of therapeutic air surfaces and bed rails.

The consultant indicated that the right rail on resident #001's bed system would be fixed into place that afternoon. As well, the consultant indicated that the resident would be observed and assessed while in bed over a period of days to determine if the left rail was truly necessary.

On December 21, 2016, at approximately 10:40 hours, the RAI coordinator conducted a Zone three test on the left rail of resident #001's bed system in the presence of the DOC, the consultant and the Inspector. This was done to confirm or refute the assumption that such a bed system would fail the test. Zone three is the space between the inside surface of the rail and the mattress compressed by the weight of a resident's head. The testing process as prescribed by the HC guidance document, by use of the cone only, was reviewed by the RAI coordinator prior to performing the test. The line across the flat end of the cone settled below the top surface of the therapeutic air surface once the cone was left to sink into the space by its own weight. It was therefore confirmed that Zone three failed the testing process on the left rail. The air surface did not have a firm perimeter or reinforced side walls. It was also noted

that the full bed rails in use for resident #001 were the same style, on the same type of bed frame, as what was in use for resident #002 and #003. It was established on December 20th, 2016 that these bed systems failed the Zone two testing.

On the afternoon of December 21, 2016, the consultant informed the Inspector that resident #001 had been assessed and it had been determined that resident #001 did not require a therapeutic air surface. The consultant informed that the resident would be given a new mattress on December 22, 2016. The consultant indicated that she would roll up blankets and stuff them into the space between the left rail and the mattress in the meantime, in an effort to mitigate the potential entrapment risk of Zone two, three and four. As well, the consultant indicated that staff would be reminded to keep resident #001's bed in the flat position when the resident was in bed, in an effort to mitigate the potential risk of entrapment with Zone two. The consultant acknowledged that changing the mattress was not a final solution for Zone two in light of the testing results for resident #002 and #003's bed systems. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 27, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 27th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

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