Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

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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 18, 2016	2015_205129_0022	032903-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

RIDGEVIEW
385 HIGHLAND ROAD WEST STONEY CREEK ON L8J 3X9

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

PHYLLIS HILTZ-BONTJE (129), BERNADETTE SUSNIK (120), KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 30, December 1, 2, 3, 4, 8, 9, 10, and 14, 2015

Three Critical Incident System (CIS) inspections were completed concurrently with this inspection. CIS inspection #013964-15 related to an injury sustained during transportation, CIS #019203-15 related to an injury for which the resident was transferred to hospital and CIS # 029685-15 related to inappropriate touching.

During the course of the inspection, the inspector(s) spoke with residents and resident's family members, representatives of both Resident's Council and Family Council ,the Administrator, Director of Care, Program Manager, Resident Services Coordinator/Staff Educator, Food Services Manager, Environmental Services Manager, Resident Assessment Instrument-Minimum Data Set (RIA-MDS) Coordinator, Quality Control Manager as well as registered and unregulated nursing staff.
During the course of this inspection, inspectors also observed care provided to residents, toured the home, observed meal and snack services, reviewed clinical documentation and records, reviewed records maintained by the home (bed safety audits, 2014 staff training records as well as Resident and Family Council meeting minutes) and reviewed home polices and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Safe and Secure Home
Snack Observation
Sufficient Staffing

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 did not ensure that where bed rails were used, that the residents were assessed and their bed systems evaluated in accordance with prevailing practices, to minimize risk to the residents.

A) On May 4, 2015, 120 bed systems were assessed by an external company and 19 were determined to have failed one or more zones of entrapment (2, 3 or 4). The company used a specialized tool called a "cone and cylinder tool" designed for bed systems which is in accordance with Health Canada's "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006". During the inspection, observations of some of the beds led Inspector #120 to question the status of the beds and documentation was requested for confirmation. On December 10, 2015, the information presented included that 9 out of the 19 failed beds had a "beveled mattress: no entrapment issues" and the other 10 were being used as "per resident preference" or the resident did not use bed rails. When the licensee's "Bed Entrapment Checklist" was reviewed for each of the 19 beds re-evaluated on December 9, 2015 by the maintenance person, none of the questions on the form included whether the bed had any of the 4 zones of entrapment tested. The questions were limited to whether or not the bed had mattress keepers, the correct sized mattress and a firm perimeter or if the bed rails were secure. The maintenance person confirmed that no specialized tool was used when he evaluated the beds and was informed that if the bed had a raised perimeter (beveled) mattress, the bed would pass entrapment. The bed system assessment was not developed or completed in accordance with Health Canada's guidelines noted above. The maintenance person reported that the cone and cylinder tool was delivered to the home only days prior to the inspection and training on the use of

the tool was pending.

B) According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be evaluated by an interdisciplinary team, over a period of time, while in bed, by answering a series of questions to determine if the bed rail is a safe device for resident use. The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or the resident's Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail clinical assessment form was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified in the above guideline. According to the Director of Care, the document listed above had not been reviewed or incorporated. Based on discussions, a review of the available questions and decision trees used (LTC-K-10 Appendix B and LTC-K-10-05-ON), an interdisciplinary team was involved in assessing each resident for rail use based on limited questions geared to cognition, mobility and transfer capabilities. Other factors were not included. No documentation was kept as to whether interventions were used and if they were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident or whether alternatives were trialled before coming to a conclusion. No documentation was available identifying what interventions or changes were made to the bed system if the resident's bed system was assessed to have passed or failed any of the entrapment zones. During the inspection, documentation was provided from a company hired to test the beds in May 2015 that 19 beds failed more than one entrapment zone. The clinical assessments completed for some of these residents was reviewed, however no information was documented on their assessments about the type of risk identified and what was done to address the risk

to the resident. [s. 15. (1) (a)]

2. The licensee did not ensure that where bed rails were used that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) During a tour of several home areas on December 9 and 10, 2015, the majority of resident beds were observed to have at least one bed rail elevated or engaged and the beds unoccupied with the exception of two beds. Resident #500 and resident #501 were both observed to be in bed on December 9, 2015 with one half rail elevated. According to a document prepared by an external company on May 4, 2015 who tested all of the bed systems for entrapment hazards, the two beds noted above did not pass zones of entrapment 2, 3 and 4. The plan of care for both residents identified that they required one half rail for repositioning while in bed, but no information was available about the potential zone risks. No bed rail pads or bolsters (gap fillers) were employed to mitigate the gaps in the three zones. Although the residents were assessed for their bed rail needs, they were not assessed to determine whether they were likely to become entrapped in zones 2, 3 or 4 based on their condition and physical abilities.

The Director of Care reported that residents who were assessed as requiring the use of one or more bed rails and who had a bed that did not pass all zones of entrapment, were cognitively alert and provided with bed safety entrapment risk information. Some residents chose to continue using the bed rails. No additional steps were taken by the management staff to ensure that the bed systems were safer by using zone mitigating accessories or giving the resident a different bed that passed all zones of entrapment.

B) The bed systems safety audit report completed on May 4, 2015 identified that the mattresses on 95% of the beds were sliding side to side because no mattress keepers were equipped on the bed (on the 4 corners). The document included written suggestions to install mattress keepers. Verification was made at the time of inspection that certain types of mattresses were quite easy to move side to side, specifically but not limited to 7 identified rooms. All of the residents using these beds were confirmed to require at least one bed rail while in bed, according to their plan of care. During the inspection, these beds were all observed to have at least one rail elevated while unoccupied. The concern was raised with the Administrator that if residents slept on any of these beds, whether they failed or passed entrapment, that a gap could form on the side with the elevated rail and create an entrapment zone. Without mattress keepers, the mattresses had no stopping point and could easily slide away from the one elevated rail. Resident #107 reported to Inspector #583 during the inspection that their mattress was

moving around too much and causing them to have concerns of the mattress sliding off the deck of the bed. The management staff did not have any plans in place to address the issue of sliding mattresses and the potential they could have on resident safety.

Discussion was held with the Director of Care as to the reasons why bed rails were being left in the elevated position when residents were not in bed. Some of the reasons given were related to staff habits or resident preference. Based on 19 care plans reviewed, none identified that a bed rail was required to be elevated when a resident was out of the bed. Staff were not following the plan of care with respect to when the bed rails were to be employed and were therefore not involved in taking steps to ensure that resident entrapment risks be minimized. No formal training had been provided to all health care staff in 2014 or 2015 regarding bed safety, clinical assessments, when to apply bed rails, their risks and interventions required to ensure the resident was safe in their bed system. [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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

A review of resident #104's oral hygiene care plan identified they had their own teeth and required total assistance with oral care using a manual toothbrush. A sign posted in the resident's room directed staff in relation to the specific equipment to be used when providing oral hygiene. On December 9, 2015, at 0840 hours and 1100 hours resident #104's manual tooth brushes were observed and appeared dry and to have not been recently used. In an interview with PSW staff #012 on December 9, 2015, it was shared that resident #104's morning oral care was completed using equipment not specified in the resident's plan of care. In an interview with registered staff #011 it was confirmed that the oral care provided was not completed as specified in the plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed, in relation to the following: [6(10)(b)]
Resident #103 was not reassessed when data collected and documented in the clinical record indicated the resident's bowel continence had changed. Data collected during a Minimum Data Set (MDS) review on March 2015 indicated that the resident was continent of bowel. Data collected during the following MDS review on June 2015 indicated the resident bowel continence had changed when it was identified that the resident was now usually continent of bowel. Registered staff #007, #008 and clinical documentation confirmed that a non-triggered resident assessment protocol (RAP) had not been completed, a clinical note identifying the change in the resident's condition had not been documented and the resident's plan of care had not been altered when it was identified that the resident's care needs related to bowel continence had changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that care set out in the plan of care is provided to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place in place any policy, the licensee is required to ensure that the policy, is complied with.
A review of resident #300's plan of care identified they fell on an identified date. Resident #300 sustained a fracture which required surgery. In an interview with administrative staff #002 on December 4, 2015, it was verified that four staff members where present at the time of the incident. It was confirmed that neither the resident's wheel chair seat belt or other safety system available were in place at the time of the incident. The care plan completed in July 2015, identified resident #300 required total assistance with the activities of daily living. A review of the Recreation Services, Community Outings policy (LTC-I-30) revised November 2013, stated "Staff will ensure that all security belting systems are in full and proper use for all persons (ambulatory and wheelchair) being transported (if applicable)". In an interview with administrative staff #001 on December 9, 2015, it was confirmed the required organized program of recreation and social activities, Community Outings policy was not complied with.

(PLEASE NOTE: This evidence of non-compliance was found during the inspection of critical incident #019203-15) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that were the Act or the Regulation requires the licensee to have, institute or otherwise put in place any policy, that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a between-meal beverage was offered in the morning to residents.

In an interview with resident #105 and #107 on December 1, 2015, it was shared that they were not always offered a beverage and/or snack between meals. A review of the snack service schedule times identified that beverages were served daily at 1000 hours. On December 4, 2015, on Erland Lee House and Gage House the beverage cart was observed to be set up by dietary staff and ready for distribution to residents by 1000 hours. During three observations on each unit between 1000 hours and 1115 hours it was observed that residents had not been offered a beverage. In an interview with management staff #005 it was confirmed that the snack service had not been initiated on Erland Lee House or Gage House. In an interview with resident #105 and #107 on December 4, 2015, at 1140 hours they shared that they had not been offered a between meal beverage. [s. 71. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that between meal beverage is offered in the morning to residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that if Family Council advised the licensee of concerns or recommendations about the operation of the home, the licensee has, within 10 days of receiving the advice, responded to Family Council in writing. [60(2)]
Two representatives of Family Council indicated that they did not consistently receive a response from the home within 10 days of raising issues of concern or making recommendations. A review of Family Council minutes indicated that on February 4, 2015 the minutes reflected a concern expressed related to residents falling, Council recommended that night lights should be provided for all residents and a concern was also raised related to staff shortages. There was no indication that a written response was provided within 10 days to the Council about the above noted issues. The minutes of the October 7, 2015 Council meeting indicated that the council raised concerns related to making beds and concerns about missing clothing and there was no indication that a written response was provided within 10 days to Council about these two concerns. The Administrator confirmed that there is not currently a formal process in place for providing written responses to concerns raised or recommendations made by Family Council. [s. 60. (2)]

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

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Issued on this 18th day of January, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129), BERNADETTE SUSNIK (120), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2015_205129_0022
Log No. / Registre no:	032903-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 18, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	RIDGEVIEW 385 HIGHLAND ROAD WEST, STONEY CREEK, ON, L8J-3X9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANNE D'AMBROSIO

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1. Immediately conduct and document the results of a mattress audit indicating which beds have mattresses that easily slide side to side while on the deck of the bed while the bed rails are down or in the transfer position. For those that easily slide side to side, secure the mattresses (either by equipping the bed with mattress keepers or replacing the mattress with a heavier style of mattress) beginning with those beds where one or more bed rails are used by residents assessed as high risk for entrapment, whether in the raised position for ¼ or ¾ sized bed rails or in the "transfer" or "guard" position for rotating assist rails while the resident is in bed. The remaining beds and mattresses with safety concerns shall be addressed by March 1, 2016.
2. Develop a form or tool incorporating the guidelines identified in the document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Implement the tool or form in the process of assessing residents for bed rail use and bed rail safety concerns.
3. Bed safety education shall be provided to all staff who provide care to residents by March 31, 2016. The education at a minimum shall include information related to bed entrapment zones 1-4, when to apply bed rails, how staff will be informed as to when to apply bed rails, how to recognize when a bed is unsafe, how and when to report bed safety concerns, how residents are assessed for bed rail use and how to apply any entrapment zone interventions if necessary.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, that the residents were assessed and their bed systems evaluated in accordance with prevailing practices, to minimize risk to the residents.

A) On May 4, 2015, 120 bed systems were assessed by an external company and 19 were determined to have failed one or more zones of entrapment (2, 3 or 4). The company used a specialized tool called a "cone and cylinder tool" designed for bed systems which is in accordance with Health Canada's "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006". During the inspection, observations of some of the beds led Inspector #120 to question the status of the beds and documentation was requested for confirmation. On December 10, 2015, the information presented included that 9 out of the 19 failed beds had a "beveled mattress: no entrapment issues" and the other 10 were being used as "per resident preference" or the

resident did not use bed rails. When the licensee's "Bed Entrapment Checklist" was reviewed for each of the 19 beds re-evaluated on December 9, 2015 by the maintenance person, none of the questions on the form included whether the bed had any of the 4 zones of entrapment tested. The questions were limited to whether or not the bed had mattress keepers, the correct sized mattress and a firm perimeter or if the bed rails were secure. The maintenance person confirmed that no specialized tool was used when he evaluated the beds and was informed that if the bed had a raised perimeter (beveled) mattress, the bed would pass entrapment. The bed system assessment was not developed or completed in accordance with Health Canada's guidelines noted above. The maintenance person reported that the cone and cylinder tool was delivered to the home only days prior to the inspection and training on the use of the tool was pending.

B) According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be evaluated by an interdisciplinary team, over a period of time, while in bed, by answering a series of questions to determine if the bed rail is a safe device for resident use. The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or by the resident's Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail clinical assessment form was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified in the above guideline. According to the Director of Care, the document listed above had not been reviewed or incorporated. Based on

discussions, a review of the available questions and decision trees used (LTC-K-10 Appendix B and LTC-K-10-05-ON), an interdisciplinary team was involved in assessing each resident for rail use based on limited questions geared to cognition, mobility and transfer capabilities. Other factors were not included. No documentation was kept as to whether interventions were used and if they were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident or whether alternatives were trialled before coming to a conclusion. No documentation was available identifying what interventions or changes were made to the bed system if the resident's bed system was assessed to have passed or failed any of the entrapment zones. During the inspection, documentation was provided from a company hired to test the beds in May 2015 that 19 beds failed more than one entrapment zone. The clinical assessments completed for some of these residents was reviewed, however no information was documented on their assessments about the type of risk identified and what was done to address the risk to the resident.

(120)

2. The licensee did not ensure that where bed rails were used that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) During a tour of several home areas on December 9 and 10, 2015, the majority of resident beds were observed to have at least one bed rail elevated or engaged and the beds unoccupied with the exception of two beds. Resident #500 and resident #501 were both observed to be in bed on December 9, 2015 with one half rail elevated. According to a document prepared by an external company on May 4, 2015 who tested all of the bed systems for entrapment hazards, the two beds noted above did not pass zones of entrapment 2, 3 and 4. The plan of care for both residents identified that they required one half rail for repositioning while in bed, but no information was available about the potential zone risks. No bed rail pads or bolsters (gap fillers) were employed to mitigate the gaps in the three zones. Although the residents were assessed for their bed rail needs, they were not assessed to determine whether they were likely to become entrapped in zones 2, 3 or 4 based on their condition and physical abilities.

The Director of Care reported that residents who were assessed as requiring the use of one or more bed rails and who had a bed that did not pass all zones of

entrapment, were cognitively alert and provided with bed safety entrapment risk information. Some residents chose to continue using the bed rails. No additional steps were taken by the management staff to ensure that the bed systems were safer by using zone mitigating accessories or giving the resident a different bed that passed all zones of entrapment.

B) The bed systems safety audit report completed on May 4, 2015 identified that the mattresses on 95% of the beds were sliding side to side because no mattress keepers were equipped on the bed (on the 4 corners). The document included written suggestions to install mattress keepers. Verification was made at the time of inspection that certain types of mattresses were quite easy to move side to side, specifically but not limited to seven identified rooms. All of the residents using these beds were confirmed to require at least one bed rail while in bed, according to their plan of care. During the inspection, these beds were all observed to have at least one rail elevated while unoccupied. The concern was raised with the Administrator that if residents slept on any of these beds, whether they failed or passed entrapment, that a gap could form on the side with the elevated rail and create an entrapment zone. Without mattress keepers, the mattresses had no stopping point and could easily slide away from the one elevated rail. Resident #107 reported to Inspector #583 during the inspection that their mattress was moving around too much and causing them to have concerns of the mattress sliding off the deck of the bed. The management staff did not have any plans in place to address the issue of sliding mattresses and the potential they could have on resident safety.

Discussion was held with the Director of Care as to the reasons why bed rails were being left in the elevated position when residents were not in bed. Some of the reasons given were related to staff habits or resident preference. Based on 19 care plans reviewed, none identified that a bed rail was required to be elevated when a resident was out of the bed. Staff were not following the plan of care with respect to when the bed rails were to be employed and were therefore not involved in taking steps to ensure that resident entrapment risks be minimized. No formal training had been provided to all health care staff in 2014 or 2015 regarding bed safety, clinical assessments, when to apply bed rails, their risks and interventions required to ensure the resident was safe in their bed system. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 18th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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