Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 27, 2012	2012_072120_0051	Critical Incident

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

ORCHARD TERRACE CARE CENTRE
199 GLOVER ROAD, STONEY CREEK, ON, L8E-5J2

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, registered staff and non-registered staff.

During the course of the inspection, the inspector(s) viewed the bed and mattress systems in various resident rooms, reviewed the identified resident care records, took measurements of the illumination levels on both the main floor corridor and basement corridor and reviewed various policies and procedures. (H-000960-12)

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

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).

Findings/Faits saillants :

[O. Reg. 79/10, s. 15(1)(a)] The licensee of a long term care home did not 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.

In 2012, information retrieved from progress notes made by staff for resident #001 identified concerns on two occasions with the resident's positioning when on the air mattress with bedside rails raised. Although the resident was not injured in either case, the resident's bed system was not evaluated in accordance with evidence-based practices to minimize potential risks to the resident when bed rails are in use.

Resident #001 was assessed after their admission in 2011 and required a therapeutic air mattress for a medical condition, however the risks of having both bed rails in the up position while the resident is in bed were not considered with the implementation of the air mattress. According to registered staff and a physician's order, bed rails were implemented for "safety reasons" , however the specific reasons were not listed.

The home's policy #E-05 titled "Bed Rails" requires that the resident be assessed at the time of admission to determine if bed rails are required, if their use would increase risk of entrapment with a therapeutic mattress and that bed rails are checked to ensure they remain secure when subject to forces of normal use. The policy describes the various entrapment zones of a bed and instructs staff to "apply bed rails in accordance with any manufacture's instructions".

According to the staff who were working during an incident that occurred with resident #001, the resident's bed had two full length bed rails in the raised position. However, staff could not confirm whether both bed rails were properly latched. The resident's care records and staff interviews confirm the condition of the mattress cover and the resident's physical response while on the mattress. This was well known to staff since mid 2011 and according to some staff, a reason why the bed rails were in use. Following the incident, an assessment was made by the Director of Care to remove the air mattress due to it's condition, exchange it with a foam mattress and provide the resident with an electric hi/low bed which could be lowered closer to the floor.

The air mattress used by resident #001 was observed to be in use by resident #002 at the time of inspection. Staff reported that resident #002 had been found in an unsafe position since receiving the air mattress in 2012. A very large gap was noted between the air mattress and the bed rail, the condition of the air mattress was confirmed as identified by staff and the air mattress did not have re-enforced side walls for edge stability or bolsters to prevent body parts from gaining access into existing gaps.

The management of the home reported that none of the beds in the home, where bed rails are in use, have been evaluated for entrapment zone risks using Health Canada's Guideline titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Reliability and Other Hazards".

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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.TABLEHomes to which the 2009 design manual appliesLocation - LuxEnclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 322.92 lux continuous consistent lighting throughoutIn all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 luxAll other homesLocation - LuxStairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 215.28 lux continuous consistent lighting throughoutIn all other areas of the home - Minimum levels of 215.84 luxEach drug cabinet - Minimum levels of 1,076.39 luxAt the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 luxO. Reg. 79/10, r. 18, Table.

Findings/Faits saillants :

1. The lighting requirements as set out in the lighting table are not being maintained.

Lighting illumination levels were measured with a light meter in the corridors located on the main floor and basement levels. The main floor corridor was notably dark and verified with a light meter to be between 0 and 600 lux. One particular area near room #155 has approximately 15 feet between ceiling light fixtures. Directly below one ceiling fixture, illumination levels were 150 lux and 0 lux between the fixtures. In another area, near room #137, the distance between ceiling light fixtures was approximately 8 feet and the lux levels 75. Some fixtures were noted to be 450 and 600 lux, however the lighting was not continuous down the corridor. The wall sconces had no effect on illumination levels. The basement corridor had better lux levels with more ceiling light fixtures, however the levels remained below the continuous 212.75 lux requirement. As residents have access to the basement to reach an activity space and hair salon, the basement areas must comply with this section.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the lighting requirements as set out in the table are maintained, to be implemented voluntarily.

Issued on this 7 th day of August, 2012

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

B. Smith

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2012_072120_0051
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jun 27, 2012
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	ORCHARD TERRACE CARE CENTRE 199 GLOVER ROAD, STONEY CREEK, ON, L8E-5J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~CHARLOTTE NEVILLS~~ Leslie Watson

To RYKKA CARE CENTRES 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) (b)

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 prepare, submit, and implement a plan to ensure that where bed rails are used, all residents' bed systems are evaluated according to evidence based practices/prevailing practices to prevent entrapment and minimize risk to residents.

The plan shall be submitted to Bernadette Susnik by August 31, 2012 by mail, e-mail or fax;

Address: LTC Homes Inspector, Ministry of Health and Long Term Care, Performance and Improvement and Compliance Branch, 119 King St. W, 11th Floor, Hamilton, ON L8P 4Y7
Fax: 905-546-8255
E-mail: Bernadette.Susnik@Ontario.ca

Grounds / Motifs :

1. [O. Reg. 79/10, s. 15(1)(a)] The licensee of a long term care home did not 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.

In 2012, information retrieved from progress notes made by staff for resident #001 identified concerns on two occasions with the resident's positioning when on the air mattress with bedside rails raised. Although the resident was not injured in either case, the resident's bed system was not evaluated in accordance with evidence -based practices to minimize potential risks to the resident when bed rails are in use.

Resident #001 was assessed after their admission in 2011 and required a therapeutic air mattress for a medical condition, however the risks of having both bed rails in the up position while the resident is in bed were not considered with the implementation of the air mattress. According to registered staff and a physician's order, bed rails were implemented for "safety reasons" , however the specific reasons were not listed.

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According to the staff who were working during an incident that occurred with resident #001, the resident's bed had two full length bed rails in the raised position. However, staff could not confirm whether both bed rails were properly latched. The resident's care records and staff interviews confirm the condition of the mattress cover and the resident's physical response while on the mattress. This was well known to staff since mid 2011 and according to some staff, a reason why the bed rails were in use. Following the incident, an assessment was made by the Director of Care to remove the air mattress due to it's condition, exchange it with a foam mattress and provide the resident with an electric hi/low bed which could be lowered closer to the floor.

The air mattress used by resident #001 was observed to be in use by resident #002 at the time of inspection. Staff reported that resident #002 had been found in an unsafe position since receiving the air mattress in 2012. A very large gap was noted between the air mattress and the bed rail, the condition of the air mattress was confirmed as identified by staff and the air mattress did not have re-enforced side walls for edge stability or bolsters to prevent body parts from gaining access into existing gaps.

The management of the home reported that none of the beds in the home, where bed rails are in use, have been evaluated for entrapment zone risks using Health Canada's Guideline titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Reliability and Other Hazards". (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board

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

and the

Director

Director
c/o Appeals Clerk
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.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

Issued on this 7th day of August, 2012

Signature of Inspector / Signature de l'inspecteur : B. Susnik

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

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