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

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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
Aug 21, 2015	2015_189120_0062	H-002318/2321-15	Follow up

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

TELFER PLACE
245 GRAND RIVER STREET NORTH PARIS ON N3L 3V8

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 29, 2015

Critical Incident Inspections (2742-000017-14/H-001093-14 & 2742-000-15/H-002889-15) were completed concurrently with this follow up visit. The first incident involved the burning of butter on an unattended stove in the kitchen causing a shut down of the kitchen for clean up and the second incident related to an over bed light sparking and smoking in a resident bedroom.

An inspection was conducted March 4-12, 2015 and non-compliance was identified with respect to snack service and bed safety. Orders #001 and #004 were issued as a result. For this follow-up visit, the licensee did not meet all of the conditions required in Order #001 related to bed safety. See below for details.

During the course of the inspection, the inspector(s) spoke with the Administrator, Food Services Supervisor, Director of Care, Associate Director of Care, Restorative Care Manager, Personal Support Workers and maintenance person.

During the course of the inspection, the inspector toured the home including random resident bedrooms, observed the morning snack pass and snack diet lists, reviewed bed system entrapment audit records, resident care plans and resident clinical bed rail safety assessments.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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
O.Reg 79/10 s. 71. (3)	CO #004	2015_188168_0007	120

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 residents were assessed in accordance with prevailing practices to minimize risk to the resident.

Based on a tour of the home on July 29, 2015, interventions to minimize possible entrapment risks to residents were not implemented and residents had not been assessed in accordance with prevailing practices adopted by Health Canada in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" developed by the US Food and Drug Administration.

Residents were assessed to determine if they required one or more bed rails for mobility, transfers or repositioning and this information was found in random resident care plans. However, the assessment process did not include what safety risks were associated for each specific resident using the rail for mobility, transfers or repositioning. According to the clinical guidance document, residents also need to be assessed to determine whether the bed rail would pose any harm to them while they were in bed and whether alternatives would be more suitable. The Restorative Care Co-ordinator and Director of Care provided a copy of the their "Side Rail and Alternative Equipment Decision Tree" they used to evaluate residents. When reviewed, it was not a fully comprehensive tool but a decision tree which did not include several components identified in the clinical guidance document. It was missing a written component to identify whether the resident was given alternatives, whether they were successful, how long they were used for and an evaluation of any safety risks other than entrapment risks when a bed rail was used. [s. 15 (1)(a)]

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

During a tour of the home, using the licensee's bed system entrapment audit dated June 29, 2015 which identified that 4 beds failed one or more entrapment zones, the beds were observed for any obvious signs that steps were taken to mitigate entrapment risks using any bed accessories (gap fillers, bolsters, rail pads) or alternative measures such as switching the beds or using a hi/lo bed with no rails. The Associate Director of Care (ADOC) confirmed that no accessories were available on the identified beds and had not realized that switching the beds around (passed bed with rail given to residents who need rails and failed bed given to residents who don't need rails) was an option.

1) An identified was tested and documented to have failed entrapment zone 2 on June 29, 2015. It was unoccupied at the time of inspection, yet one 1/2 rail was elevated on the left side (resident left side). The resident's plan of care reviewed on July 29, 2015 required that the resident be provided with both 1/2 rails while in bed for bed mobility. No side bolsters or gap fillers were noted on the bed and the ADOC confirmed that no accessories were available. The bed system entrapment audit identified that the 1/2 rails needed to be tightened and that the mattress be replaced. According to the maintenance person, the 1/2 rails were tightened, but no date was documented. He was unaware if a new mattress was provided and had not re-tested the bed to determine if tightening the bed rails was sufficient in reducing the entrapment gap.

2) Three identified beds were all tested and documented as having failed entrapment zone 2 on June 29, 2015. The beds were unoccupied at the time of inspection and the bed rails were not observed. The residents' plan of care was reviewed with the ADOC on August 11, 2015 and all 3 were assessed to require both 1/4 rails when in bed for bed mobility. The ADOC confirmed that no accessories were available to mitigate the identified entrapment zone. The bed system entrapment audit identified that the assist rails on all 3 beds needed to be tightened. According to the maintenance person, the assist rails were tightened, but no date was documented and the beds had not been re-tested to determine if tightening the bed rails was sufficient in reducing the entrapment gap. The ADOC confirmed that the beds did in fact have rotating assist rails on the beds on August 11, 2015. A discrepancy and some confusion was identified between the plan of care and the bed system entrapment audit.

There were no directions in any of the residents' plan of care for staff to follow regarding

the use of any entrapment mitigating accessory for beds that failed. [s. 15(1)(b)]

Additional Required Actions:

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

Issued on this 21st day of August, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2015_189120_0062
Log No. / Registre no:	H-002318/2321-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 21, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	TELFER PLACE 245 GRAND RIVER STREET NORTH, PARIS, ON, N3L-3V8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To REVERA LONG TERM CARE INC., 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: 2015_188168_0007, 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 shall:

1. Ensure that the 4 beds that were identified to have bed rails that failed any zone of entrapment during the bed system entrapment audit completed on June 29, 2015 are not in use or that the failed zone identified is modified to decrease the entrapment risk.

2. Amend or add to the existing "Side Rail and Alternative Equipment Decision Tree" a written component and additional questions related to bed rail risks as identified in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" and re-assess all residents accordingly.
3. Update the residents' plan of care to reflect what directions staff require to apply a specific intervention to ensure that the resident who resides in a bed that has failed one or more entrapment zones has the risk reduced or mitigated.
4. Implement a method and frequency to monitor the residents who require a specific intervention to ensure that the required intervention is being applied by staff and re-evaluate the intervention to determine it's effectiveness for the resident.
5. Maintain documentation of all bed systems audited so that it clearly identifies what date and the specific follow up action taken.

Grounds / Motifs :

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

Based on a tour of the home on July 29, 2015, interventions to minimize possible entrapment risks to residents were not implemented and residents had not been assessed in accordance with prevailing practices adopted by Health Canada in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" developed by the US Food and Drug Administration.

Residents were assessed to determine if they required one or more bed rails for mobility, transfers or repositioning and this information was found in random resident care plans. However, the assessment process did not include what safety risks were associated for each specific resident using the rail for mobility, transfers or repositioning. According to the clinical guidance document,

residents also need to be assessed to determine whether the bed rail would pose any harm to them while they were in bed and whether alternatives would be more suitable. The Restorative Care Co-ordinator and Director of Care provided a copy of the assessment tool they used. When reviewed, it was not a fully comprehensive tool but a decision tree which did not include several components identified in the clinical guidance document. It was missing a written component to identify whether the resident was given alternatives, whether they were successful, how long they were used for and an evaluation of any safety risks other than entrapment risks when a bed rail was used. (120)

2. The licensee did not ensure that where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the resident.

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There were no directions in any of the residents' plan of care for staff to follow regarding the use of any entrapment mitigating accessory for beds that failed.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board 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 21st day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

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

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