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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 30, 2017	2017_539120_0049	005845-17	Follow up

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

DUNDURN PLACE CARE CENTRE
39 MARY STREET HAMILTON ON L8R 3L8

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 15, 2017

An inspection (2017-539120-0005) was previously conducted on January 19 and 24, 2017, and an order was subsequently issued related to bed safety. For this inspection, the conditions laid out in the order have been addressed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care and Personal Support Workers.

During the course of the inspection, the inspector toured first and second floors, observed resident bed systems and residents in bed, reviewed resident bed safety assessments, bed safety entrapment evaluations and bed safety policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 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. 15. (1)	CO #001	2017_539120_0005	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on an assessment of the resident's needs.

Resident #101 was assessed in August 2017, for bed rail safety and sleep behaviour. The Registered Nurse (RN) concluded on the bed safety assessment that the resident, did not require bed rails. No comments were included about the need to include any particular bed accessory. The resident's written plan of care included that the resident required wedges on each side of the mattress. During the inspection, wedges were observed on each side of the mattress. When discussed with the Director of Care, as to why wedges were added, she stated that there were discussions about adding them but that it was decided that they would not meet the resident's needs. She was unaware that foam wedges were added to the resident's bed. The application of foam wedges was implemented without an adequate assessment of the resident and whether the foam wedges could pose any risks to the resident and the plan of care was therefore not based on the resident's assessed needs. [s. 6. (2)]

2. The licensee did not ensure that care, as set out in the plan of care, was provided to the resident as specified in the plan.

A. The written plan of care for resident #105 under the focus of "Activities of Daily Living-Bed Mobility" included the use of wedges on either side of the bed. It did not include the application of any bed rails at any time. When observed, the resident's bed had two rotating assist rails in the guard position on the bed in addition to the foam wedges. The application of bed rails, which are a medical device, are a risk to anyone that has not been adequately assessed for their use. The resident was assessed in June 2017, and was deemed high risk for bed rail related injury and the RN documented clearly that bed rails were not safe for the resident due to their health condition.

B. Resident beds located on both the first and second floors were observed in the morning and again in the afternoon of August 15, 2017, to have one or more bed rails either in the guard position or elevated (depending on style of rail). Beds with rotating assist bed rails were commonly observed to be applied in the guard position on the side of the bed that was next to another bed. The strategy was to ensure residents got into bed on the side that was facing away from the neighbouring bed. Although residents were not in their beds at the times of the observation, and no immediate risks were identified, the potential for bed rail related injury is high, especially when staff apply bed rails out of habit, which was the case during the inspection. A review of the written plan of care for many of the residents in the above noted rooms did not include bed rails in the guard position when not in bed. The Director of Care revealed that the expectation was that if residents were not in bed, that the bed rails would be lowered or rotated back into a neutral position or the transfer position and that staff were given training regarding the expectation.

The care set out in the plan of care was therefore not provided to the resident as specified in the plan. [s. 6. (7)]

WN #2: 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 steps were taken to prevent resident entrapment,

taking into consideration all potential zones of entrapment.

Resident #104 was assessed by a Registered Nurse (RN) using the "Bed Rails Safety and Sleep Assessment" just after admission in an identified month in 2017. The resident was assessed to require two rotating assist rails (which were labeled "partial bedrails" by the RN) in the transfer position for transferring in and out of bed and for bed mobility. The resident's written plan of care also reflected the same decision. Two months later, the resident was relocated to another room and to a different bed. The bed had a different style of bed rail which could be raised or lowered and had odd shaped openings within the bed rail. The bed rails were approximately 90 centimeters in length and were located along the center of the bed on each side. The resident's previous bed had rotating assist bed rails, which could be rotated into three different positions and had evenly spaced openings within the bed rail. When the bed rails were located in the transfer position, they were located close to the head board. According to the Bed Rail Safety and Sleep Assessment form, the resident was observed in the new bed for three nights by the RN and a Personal Support Worker. The staff documented under Section A, that the resident could not get in and out of bed or reposition themselves without bed rails, and under Section B, the opposite was identified, that the resident did not need bed rails for these tasks. Under section C, staff identified that the resident was observed getting off the bed safely by using the bed rails and that they used them for bed mobility. When the bed was observed on August 15, 2017, it was difficult to imagine how the resident could have safely managed to get off the bed with bed rails applied. The resident would have had to scoot down to the end of the bed in order to get off the bed. The assessment was confusing as it included contradictory answers.

The bed was evaluated by an external bed company on March 17, 2017, and identified to have failed entrapment zone 6, which is a space between the edge of the head board and the end of the bed rail. Although Health Canada bed safety guidelines do not have specific minimum or maximum standard measurements for this zone, they recognize that this zone needs to be evaluated or monitored for potential entrapment issues. The external contractor, which manufactures beds, identified that they acquired their standard for zone 6 from the International Electrotechnical Committee which develops standards for manufacturers of adult hospital beds. The standard was in effect as of April 1, 2013, and required bed manufacturers to ensure that zone 6 was less than 6 centimeters (female neck diameter) or greater than 31.8 centimeters (average chest breadth). The assessor documented on the bed safety audit form that the bed rail on resident #104's bed needed to be moved, either closer to the head board or further away.

During the inspection, the Director of Care and the Administrator were not aware that the bed was in use by a resident who was using the bed rails and that no steps had been taken to mitigate zone 6. When shown, the Administrator had the bed replaced with one that was in storage and had rotating assist rails and the Director of Care reviewed the resident's assessments for further clarification.

No steps were taken to ensure that the bed was mitigated in any way to reduce zone 6 entrapment when bed rails were applied, and the resident's clinical assessment for bed rail use was not reflective of the type of bed system they were given and was confusing. [s. 15. (1) (b)]

Issued on this 26th day of September, 2017

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

Original report signed by the inspector.