Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2019	2019_761733_0005 (A2)	027884-18, 029180-18, 029181-18, 029182-18, 029185-18, 006613-19	Follow up

Licensee/Titulaire de permis

Mohawk Council of Akwesasne
P.O. Box 579 CORNWALL ON K6H 5T3

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

Tsiionkwanonhsote
70 Kawehnoke Apartments Road Akwesasne ON K6H 5R7

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

Amended by JESSICA LAPENSEE (133) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance order #001, related to bed rail use, has been amended upon request from the licensee. The compliance order due date was September 16, 2019. The compliance order due date has been extended to December 16, 2019. No other changes have been made to this report.

Please note that compliance order #002 that is captured within this report, related to maintenance of residents' bed system, was subsequently reissued as a result of follow up inspection #2019_625133_0014 as order #001. The compliance date for the reissued order was initially set at September 16, 2019. The compliance date has been extended to December 16, 2019, upon request from the licensee. This change is captured in an amended report for inspection #2019_625133_0014.

Issued on this 12nd day of September, 2019 (A2)

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

Original report signed by the inspector.

Ontario

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

Amended by JESSICA LAPENSEE (133) - (A2)

Amended 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): March 25, 26, 27, 28, 29, April 1, 2, 2019

Log 029180-18 is a follow-up to a compliance order related to s.19 duty to protect.

Log 029181-18 is a follow-up to a compliance order related to s. 15 bed rails.

Log 029182-18 is a follow-up to a compliance order related to s. 31 (3) staffing plan.

Log 029185-18 is a follow-up to a compliance order related to s. 50 (2) b skin and wound care.

Log 027884-18 (CI: 2800-000016-18) and Log 006613-19 (CI: 2800-000003-19) are related to alleged abuse/neglect.

The inspectors also reviewed residents' health care records, home policies and procedures, mandatory training records, staff work schedules, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including resident-staff interactions.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Administrator, the Activities and Education Manager, the Food Services Supervisor, Maintenance Supervisor, Registered Practical Nurses, Registered Nurses, Personal Support Workers, Personal Support Worker Instructors, Dietary Aides, Housekeeping staff, Finance Clerk, Administration Clerk, RAI/MDS Coordinator.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of the original inspection, Non-Compliances were issued.
7 WN(s)
2 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_583117_0007	733
O.Reg 79/10 s. 31. (3)	CO #003	2018_583117_0007	117
O.Reg 79/10 s. 50. (2)	CO #004	2018_583117_0007	117

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

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

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

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order (CO) #002 from Resident Quality Inspection #2018_583117_0007. The CO was served in October, 2018, with a compliance date of January 31, 2019.

The compliance order was as follows:

The licensee shall be compliant by:

1) Ensuring that bed rail use, for resident #007 and all other residents in the home, are assessed and implemented in accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003). This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment, following the resident assessment by the interdisciplinary team, where bed rails are in use. The documented risk benefit assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

c) Documented approval of the use of bed rails for an individual resident by the interdisciplinary team that conducted the resident's assessment and the final risk benefit assessment. The names of the team members are to be documented.

2) Update the written plan of care based on the resident's assessment/reassessment by the interdisciplinary team. Consider the factors

referenced with regards to the sleeping environment assessment, the treatment programs/care plans section and the risk intervention section of the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) when updating the written plan of care. The written plan of care is to reflect the assessed use and position of bed rails with intermediate locking and stopping positions should these be an assessed needs for residents.

3) Evaluate all resident's bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" to minimize risk to the resident. Ensure that bed rails with intermediate locking and stopping positions are evaluated in all positions as prescribed by the above document.

4) Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment.

In relation to evidence based and prevailing practices:

In August, 2012, the Ministry of Health and Long-Term Care issued a memo to all Long-Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the HC guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" was to be used by all homes as a best practice document. The HC guidance document identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

The HC guidance document includes the titles of two additional companion documents. The referenced companion documents are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is a clinical practice guideline, titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care

Facilities and Home Care Settings, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used. The second companion document is titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, FDA, 2006" (The Mitigation Guide). The purpose of the document is to assist in the reduction of risk of entrapment in existing hospital bed systems.

The licensee did not complete step 1 in that bed rail use for resident #007, and for all residents was not assessed and implemented in accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003)". It is noted that an assessment form titled "Bed Rail Risk" was developed and completed by RAI Coordinator #128 for residents with bed rails in use. This form provides for the consideration of risk of injury, a component of a risk benefit assessment. It was also noted that this form was not completed for resident #017, #018, #019, #020 and resident #021. Inspector #733 noted that bed rails were present on the beds of resident #017, #018, #019, #020 and resident #021. The inspector confirmed with resident #017 that they use the bed rails for support. The inspector confirmed with RN #104 that resident #018 uses the bed rails for safety and repositioning. Resident #019 indicated that they did not use their bed rails, however according to this resident's care plan, they use two half bed rail when in bed for positioning. RPN #103 did not believe that resident #020 uses their bed rails and this was confirmed by reviewing their care plan. It was confirmed with RPN #103 that resident #021 uses their bed rails for safety.

A review of resident #017, #018, #019, #020 and resident #021's chart indicated that no "Bed Rail Risk" had been completed. A review of the binder that contains hard copies of these assessments did not produce any for these residents.

The licensee did not complete step 2 in that there was no interdisciplinary team assessment process developed and implemented, and therefore residents' written plan of care were not updated accordingly.

The licensee did not complete step 3 in that where bed rails are used, resident bed systems were not evaluated in accordance with the Health Canada Guidance

Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008".

The licensee did not complete step 4 in that entrapment zone testing had not been conducted, and therefore it is not yet known if any bed systems would fail.

Related to the assessment of residents, where bed rails are used, in accordance with prevailing practices to minimize risks to the residents:

As per the FDA clinical guidance document: Decisions to use or discontinue use of bed rails is to be made in the context of an individual resident assessment using an interdisciplinary team with input from the resident and family or the resident's legal representative. The factors to be included in the resident assessment are prescribed. Following the resident assessment, a risk benefit assessment (as prescribed) is to be documented in the resident's health care record. The use of bed rails is to be based on the resident's assessed medical needs, documented clearly and approved by the interdisciplinary team. If clinical and environmental interventions have proven unsuccessful in meeting the residents assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used.

Director of Care #100 indicated that an interdisciplinary team was not in place to conduct resident assessments as specified, to produce the subsequent risk benefit assessment as prescribed, or to make final decisions about bed rail use. Director of Care #100 indicated that the "Bed Rail Risk" form was created by RAI Coordinator #128 and the plan was to assemble a team to review and discuss the information following their completion by the RAI Coordinator. It was noted that the form did not include all the specified factors as indicated in 1) a) of the compliance order. It was noted that while the form considered the notion of risk of injury, the form did not provide for consideration of or trialing of alternatives to bed rails, nor did it result in a risk vs. benefit consideration. Answering the four questions in section one led to a concluding statement of: "Yes. Consider using a bed with bed rails for this resident" or "No. This resident is not suitable for a bed with the use of bed rails". The DOC indicated that this would not imply a final decision about bed rail use for the residents. In the final section, #5 "Determination of Bed rail use", there were three items that could be selected. Related to a final determination about bed rail use, #5A.1 could be selected and was as follows "Use bed with/without the use of bed rails". This selection did not

allow for the distinction between using a bed with or without bed rails. The other two items that could be selected related to use of the height feature on the bed.

In summary, it was determined that the home's assessment and decision making process regarding bed rail use was not in accordance with the prevailing practices outlined in the FDA clinical guidance document and as was specified in the compliance order.

Related to the evaluation of residents' bed systems, where bed rails are used, in accordance with evidence-based practices to minimize risk to the residents:

The Director of Care indicated that entrapment zone testing had not been done on any of the bed systems in the home. Bed systems had been evaluated in the sense that they were inspected in January, 2019 in order to identify issues that may impact on entrapment zone testing, such as loose bed rails. Non-compliance related to bed maintenance is identified in WN #2 with the additional action of a Compliance Order.

The severity of the issues identified was determined to be a level 2, in that there was the potential for actual harm. The scope of the issues identified was widespread, at level 3. The home had a compliance history of 4, in that non-compliance continues despite the Compliance Order previously issued. Compliance Order #002 was served to the licensee in October, 2018 in relation to bed rail use, as a result of Resident Quality Inspection #2018_583117_0007. Consequently, a subsequent compliance order will be served to the licensee. [s. 15. (1) (a)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that bed systems are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

In an interview with Inspector #133 and Inspector #733, Maintenance Supervisor #127 indicated that there is no preventative maintenance program in place for bed systems in the home. Maintenance Supervisor #127 further indicated that when bed system maintenance issues are reported, they are addressed.

PSW #109 indicated that all bed systems in the home had been evaluated in January 2019 in order to identify maintenance issues that may impact upon entrapment zone testing that was planned for the future.

Inspector #133 reviewed 51 Bed System Measurement Device Test Results Worksheets, which had been completed by PSW #109. Inspector #133 noted that the worksheets were dated January 8th or 9th, 2019. As per the worksheets, maintenance issues were identified on the majority of the bed systems in the home. PSW #109 indicated that Maintenance Supervisor #127 had not been provided with the information from the worksheets. Maintenance Supervisor #127 and PSW #109 indicated that some of the following maintenance issues may have already been corrected and that a record of these repairs may not exist as some repair requests are done verbally without a written record into a maintenance log. As per the worksheets, loose bed rails were identified for 44 bed systems. Broken bed rails were noted for three bed systems. A new remote was needed for five bed systems. On one of the five bed systems requiring a new

remote it was noted that the foot of the bed could no longer be elevated. Mattress braces had gone missing from the head and/or the foot of the bed on approximately 11 bed systems. PSW #109 stated that mattress braces are used to prevent the mattress from slipping out of position. They further indicated that mattresses were noted to be too big as they did not fit into the braces or would not fit into braces if they were present. Mattresses were noted as being too big on 15/51 bed systems.

During a telephone interview, PSW #109 indicated that that morning, the maintenance issues identified on 18 bed systems had been corrected. PSW #109 indicated that it had been determined that bed decks were adjustable, and the noted issue of mattresses that were too big had been resolved for five bed systems. PSW #109 indicated that some mattress braces had been found in the housekeeping room that day and PSW #109 indicated that missing braces had been replaced on three bed systems. PSW #109 indicated that loose bed rails had been tightened on 15 bed systems. The home planned on continuing with repairs over subsequent days until it could be verified that all of the maintenance issues identified in January 2018 had been addressed.

Seven of the bed systems missing braces were Invacare CS Series bed systems. The manufacturer references the braces as mattress keeper rods. The user manual for these bed systems specifies "Warning: (Risk of Injury or Damage) By securing the mattress in place, the mattress keeper rods prevent unsafe gaps from forming between the bed ends or rails and the mattress. Install the mattress keeper rods correctly to decrease the risk of patient entrapment". For six of the seven bed systems missing mattress keeper rods, it was noted that the mattress was too big. For four of the CS series bed systems with both mattress keepers rods, it was noted that the mattress was too big. Bed rails were in place on all of the bed systems. Further related to mattress keepers and the mattress size, the user manual specifies "Patient ENTRAPMENT with Assist Rail or Assist Bar may cause injury or death. Mattress must fit snugly within the mattress keepers to prevent resident entrapment…"

Three of the bed systems missing braces were Basic American Metal Product bed systems. The worksheets noted that the mattresses were "OK, unless braces applied".

It was determined that there was 25 Invacare CS Series bed systems in use in the home. The Invacare CS series bed system user manual, as provided by the

home, outlined the requirement for an annual maintenance program.

It was determined that there was 13 MC Health Care Products bed systems in use in the home. The user manual for these bed systems, as provided by the manufacturer, outlined a maintenance program that is to occur every six months to ensure proper functioning of the bed.

It was determined that there was three Basic American Metal Products bed systems in use in the home. The user manual as provided by the home, outlined a three month inspection program for side rails, a six month maintenance inspection program for electrical components and an annual maintenance inspection program for mechanical components.

Therefore, the licensee has failed to ensure that procedures are developed and implemented to ensure that resident bed systems are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

The severity of the issues identified was determined to be a level 2, in that there was the potential for actual harm. The scope of the issues identified was widespread, at level 3. The home had a compliance history of 2 in that it has one or more unrelated non-compliances in the last 36 months. [s. 90. (2) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training on the elements listed under s.76 (2) of the Act prior to starting their work at the home. This includes the homes policy to promote zero tolerance of abuse and neglect of residents.

Since October 2018, the home has hired five new employees including PSW #114 .

It was noted that PSW #114 had not received training and orientation on the home's policy "Resident Services 4.1 Resident Rights and Safety, 4.2 Abuse". Director of Care #100 confirmed that PSW #114 is a casual PSW who works primarily nights and some occasional evening shifts. Inspector #117 spoke with Director of Care #100, Activities and Education Manager #101 and Administration Clerk #110. None could find any information related to the PSW #114 having received any staff orientation including resident rights and Abuse and Neglect policy training prior to the start of their work at the home nor at any other time since their hire. This includes orientation to all of the other elements listed under s. 76 (2) of the Act.

Inspector #733 reviewed the homes written documentation showing that staff had completed orientation and training on the home's policy titled "Resident Services 4.1 Resident Rights and Safety, 4.2 Abuse". There was no written record of training for PSW #114.

Therefore, the licensee has failed to ensure that staff receive training on the elements listed under s.76 (2) of the Act prior to starting their responsibilities at the home. [s. 76. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff receive training on all of the elements listed under s. 76 (2) of the Act prior to starting their work in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA, 2007: it is a condition of every licensee that the licensee shall comply with every order made under this Act.

A compliance order (CO#004) was issued under O.Reg. s. 50 (2) b) related to the home's Skin and Wound Care Program in the Inspection Report # 2018_583117_007 (A1). The compliance due date was identified as being January 31, 2019. A new compliance due date of February 28, 2019 was issued on January 23, 2019 after the home had requested an extension to this order.

The licensee must be compliant with O. Reg. 79/10, s. 50 (2):

1. Ensure that residents #004, #028 and any other resident presenting with skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument designed for skin and wound assessment.

2. Ensure that residents #004 and #035, and any other resident presenting with skin breakdown, pressure ulcers, skin tears or wounds receive immediate

treatment and interventions, including specifically prescribed interventions, to promote healing and prevent infection.

3. Ensure that resident #035, and any other resident presenting with skin breakdown, pressure ulcers, skin tears or wounds, is reassessed weekly by a member of the registered nursing staff, if clinically indicated and that this assessment be documented and communicated to the attending physician during the weekly physician visits.

At the time of this inspection, residents #004 and #035 were still present at the home. A review of the identified residents' health care records as well as that of resident #016 was conducted. It was noted that residents #004, #035 and #016 have skin integrity issues requiring daily dressings.

It was noted that all three residents received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument designed for skin and wound assessment. It was also noted that all three residents skin integrity was reassessed weekly by a member of the registered nursing staff, if clinically indicated and that this assessment be documented and communicated to the attending physician during the weekly physician visits. Assessments and chart documentation indicate that all three residents' skin integrity has been improving.

All three residents #004, #035 and #016 have orders for daily dressings which include treatments and specifically prescribed interventions, to promote healing.

A review of the residents' health care record, electronic Treatment Administration Record (eTAR), 24 Hour Nursing Communication Book was conducted from March 1 to 31, 2019.

It was noted that resident #004's prescribed interventions were not done on two separate dates in 2019, that resident #035's prescribed interventions were not done on five separate dates in 2019. As well, it was noted that resident #016's prescribed interventions were not done on three separate dates in 2019.

All three residents are seen weekly by the home's attending physician who also reassesses and reviews the treatment orders. The inspector reviewed resident #004, #035 and #016 skin integrity treatments with registered nursing staff members RN #104, RPNs #103 and #106. The residents' skin integrity was

assessed and there was no evidence of any adverse effects to the residents' skin integrity when the treatments were not done on the above identified days. [s. 101. (3)]

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 resident #004, #035 and #016 and any other resident receive daily wound treatment interventions as prescribed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A Critical Incident was submitted related to staff to resident verbal abuse.

The results of the investigation were not amended to the CIS Report.

In an interview with Inspector #733, DOC #100 indicated that they did not update the CI when asked why the Director was not informed of the results of the investigation.

Therefore, the licensee failed to update the Director on the results of the investigation. [s. 23. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A Critical Incident was submitted related to staff to resident verbal abuse.

The incident occurred on a specified date in 2018 and was first reported to staff two days later. The CIS Report was first submitted to the Director two days after it was first reported to staff.

During an interview with Inspector #733, Director of Care (DOC) #100 indicated that the nurse who reported the incident the day it was first reported to staff did not contact the DOC or other management on that day.

Therefore, this incident was not immediately reported to the Director. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

A Critical Incident was submitted related to staff to resident verbal abuse.

There was no indication on the CIS Report that the resident and resident's SDM were contacted upon the completion of the investigation.

In an interview with Inspector #733, DOC #100 that they did not notify the resident or their SDM upon completion of the investigation as the resident moved to a different home before the completion of the investigation.

Therefore, the resident and resident's SDM were not notified of the results of the abuse or neglect investigation immediately upon the completion. [s. 97. (2)]

Issued on this 12nd day of September, 2019 (A2)

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

Ministère 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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JESSICA LAPENSEE (133) - (A2)
Inspection No. / No de l'inspection :	2019_761733_0005 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	027884-18, 029180-18, 029181-18, 029182-18, 029185-18, 006613-19 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 12, 2019(A2)
Licensee / Titulaire de permis :	Mohawk Council of Akwesasne P.O. Box 579, CORNWALL, ON, K6H-5T3
LTC Home / Foyer de SLD :	Tsiionkwanonhsote 70 Kawehnoke Apartments Road, Akwesasne, ON, K6H-5R7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Vincent Barry Lazore

Ontario

Ministry of Health and Long-Term Care

Ministère 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

To Mohawk Council of Akwesasne, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_583117_0007, CO #002;

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 must be compliant with O. Reg s. 15 (1)

Specifically, the licensee shall:

1) Ensure that bed rail use, for resident # #017, #018, #019, #020 and resident #021 and all other residents in the home, are assessed and implemented in accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003). This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral
symptoms; sleep habits; medication; acute medical or surgical interventions; underlying

medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment, following the resident assessment by the
interdisciplinary team, where bed rails are in use. The documented risk benefit
assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

c) Documented approval of the use of bed rails for an individual resident by the
interdisciplinary team that conducted the resident's assessment and the final risk benefit
assessment. The names of the team members are to be documented.

2) Update the written plan of care based on the resident's assessment/reassessment by the interdisciplinary team. Consider the factors referenced with regards to the sleeping environment assessment, the treatment programs/care plans section and the risk intervention section of the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) when updating the written plan of care. The written plan of care is to reflect the assessed use and position of bed rails with intermediate locking and stopping positions should these be an assessed needs for residents.

3) Evaluate all resident's bed systems where bed rails are used in the home, in
accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient

Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" to minimize risk to the resident. Ensure that bed rails with intermediate locking and stopping positions are evaluated in all positions as prescribed by the above document.

4) Take immediate corrective action should any bed system not pass entrapment zone testing. Actions taken are to be in line with the prevailing practices document "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment (FDA, 2006)".

5) Take steps to prevent resident entrapment, taking into consideration all potential zones of entrapment. This includes, but is not limited to:

a) residents' with a bed system that includes an air mattress that cannot pass entrapment zone testing and it has been concluded and documented that the therapeutic benefit outweighs the risk of entrapment, as per the Health Canada guidance document;

Steps to prevent resident entrapment shall be taken in line with the guidance provided in the two FDA prevailing practices documents previously referenced in this compliance order.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order (CO) #002 from Resident Quality Inspection #2018_583117_0007. The CO was served in October, 2018, with a compliance date of January 31, 2019.

The compliance order was as follows:

The licensee shall be compliant by:

1) Ensuring that bed rail use, for resident #007 and all other residents in the home, are assessed and implemented in accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003). This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment, following the resident assessment by the interdisciplinary team, where bed rails are in use. The documented risk benefit assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

c) Documented approval of the use of bed rails for an individual resident by the interdisciplinary team that conducted the resident's assessment and the final risk benefit assessment. The names of the team members are to be documented.

2) Update the written plan of care based on the resident's assessment/reassessment by the interdisciplinary team. Consider the factors referenced with regards to the sleeping environment assessment, the treatment programs/care plans section and the risk intervention section of the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) when updating the written plan of care. The written plan of care is to reflect the assessed use and position of bed rails with intermediate locking and stopping positions should these be an assessed needs for residents.

3) Evaluate all resident's bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" to minimize risk to the resident. Ensure that bed rails with intermediate locking and stopping positions are evaluated in all positions as prescribed by the above

document.

4) Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment.

In relation to evidence based and prevailing practices:

In August, 2012, the Ministry of Health and Long-Term Care issued a memo to all Long-Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the HC guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" was to be used by all homes as a best practice document. The HC guidance document identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

The HC guidance document includes the titles of two additional companion documents. The referenced companion documents are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is a clinical practice guideline, titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used. The second companion document is titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, FDA, 2006" (The Mitigation Guide). The purpose of the document is to assist in the reduction of risk of entrapment in existing hospital bed systems.

The licensee did not complete step 1 in that bed rail use for resident #007, and for all

residents was not assessed and implemented in accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003)". It is noted that an assessment form titled "Bed Rail Risk" was developed and completed by RAI Coordinator #128 for residents with bed rails in use. This form provides for the consideration of risk of injury, a component of a risk benefit assessment. It was also noted that this form was not completed for resident #017, #018, #019, #020 and resident #021. Inspector #733 noted that bed rails were present on the beds of resident #017, #018, #019, #020 and resident #021. The inspector confirmed with resident #017 that they use the bed rails for support. The inspector confirmed with RN #104 that resident #018 uses the bed rails for safety and repositioning. Resident #019 indicated that they did not use their bed rails, however according to this resident's care plan, they use two half bed rail when in bed for positioning. RPN #103 did not believe that resident #020 uses their bed rails and this was confirmed by reviewing their care plan. It was confirmed with RPN #103 that resident #021 uses their bed rails for safety.

A review of resident #017, #018, #019, #020 and resident #021's chart indicated that no "Bed Rail Risk" had been completed. A review of the binder that contains hard copies of these assessments did not produce any for these residents.

The licensee did not complete step 2 in that there was no interdisciplinary team assessment process developed and implemented, and therefore residents' written plan of care were not updated accordingly.

The licensee did not complete step 3 in that where bed rails are used, resident bed systems were not evaluated in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008".

The licensee did not complete step 4 in that entrapment zone testing had not been conducted, and therefore it is not yet known if any bed systems would fail.

Related to the assessment of residents, where bed rails are used, in accordance with prevailing practices to minimize risks to the residents:

As per the FDA clinical guidance document: Decisions to use or discontinue use of

bed rails is to be made in the context of an individual resident assessment using an interdisciplinary team with input from the resident and family or the resident's legal representative. The factors to be included in the resident assessment are prescribed. Following the resident assessment, a risk benefit assessment (as prescribed) is to be documented in the resident's health care record. The use of bed rails is to be based on the resident's assessed medical needs, documented clearly and approved by the interdisciplinary team. If clinical and environmental interventions have proven unsuccessful in meeting the residents assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used.

Director of Care #100 indicated that an interdisciplinary team was not in place to conduct resident assessments as specified, to produce the subsequent risk benefit assessment as prescribed, or to make final decisions about bed rail use. Director of Care #100 indicated that the "Bed Rail Risk" form was created by RAI Coordinator #128 and the plan was to assemble a team to review and discuss the information following their completion by the RAI Coordinator. It was noted that the form did not include all the specified factors as indicated in 1) a) of the compliance order. It was noted that while the form considered the notion of risk of injury, the form did not provide for consideration of or trialing of alternatives to bed rails, nor did it result in a risk vs. benefit consideration. Answering the four questions in section one led to a concluding statement of: "Yes. Consider using a bed with bed rails for this resident" or "No. This resident is not suitable for a bed with the use of bed rails". The DOC indicated that this would not imply a final decision about bed rail use for the residents. In the final section, #5 "Determination of Bed rail use", there were three items that could be selected. Related to a final determination about bed rail use, #5A.1 could be selected and was as follows "Use bed with/without the use of bed rails". This selection did not allow for the distinction between using a bed with or without bed rails. The other two items that could be selected related to use of the height feature on the bed.

In summary, it was determined that the home's assessment and decision making process regarding bed rail use was not in accordance with the prevailing practices outlined in the FDA clinical guidance document and as was specified in the compliance order.

Related to the evaluation of residents' bed systems, where bed rails are used, in

accordance with evidence-based practices to minimize risk to the residents:

The Director of Care indicated that entrapment zone testing had not been done on any of the bed systems in the home. Bed systems had been evaluated in the sense that they were inspected in January, 2019 in order to identify issues that may impact on entrapment zone testing, such as loose bed rails. Non-compliance related to bed maintenance is identified in WN #2 with the additional action of a Compliance Order.

The severity of the issues identified was determined to be a level 2, in that there was the potential for actual harm. The scope of the issues identified was widespread, at level 3. The home had a compliance history of 4, in that non-compliance continues despite the Compliance Order previously issued. Compliance Order #002 was served to the licensee in October, 2018 in relation to bed rail use, as a result of Resident Quality Inspection #2018_583117_0007. Consequently, a subsequent compliance order will be served to the licensee. [s. 15. (1) (a)] (733)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 16, 2019(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère 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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 90 (2) (a)

Specifically, the licensee shall:

1. Ensure that all identified bed system maintenance issues from January, 2019 and any subsequent issues are corrected and that this process is documented.
2. Develop a written preventative maintenance program for residents' bed systems that meets manufacturer specifications at a minimum.
3. Ensure that all manufacturer specifications for all bed systems and bed system components, such as bed frames, mattresses and bed rails, are available within the home.
4. Where the home does not have manufacturer specifications, the home is to contact the manufacturer in order to obtain said specifications.
5. Ensure that written documentation related to the preventative maintenance program is kept and maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that bed systems are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

In an interview with Inspector #133 and Inspector #733, Maintenance Supervisor #127 indicated that there is no preventative maintenance program in place for bed systems in the home. Maintenance Supervisor #127 further indicated that when bed system maintenance issues are reported, they are addressed.

PSW #109 indicated that all bed systems in the home had been evaluated in January 2019 in order to identify maintenance issues that may impact upon entrapment zone testing that was planned for the future.

Inspector #133 reviewed 51 Bed System Measurement Device Test Results Worksheets, which had been completed by PSW #109. Inspector #133 noted that the worksheets were dated January 8th or 9th, 2019. As per the worksheets, maintenance issues were identified on the majority of the bed systems in the home. PSW #109 indicated that Maintenance Supervisor #127 had not been provided with the information from the worksheets. Maintenance Supervisor #127 and PSW #109

indicated that some of the following maintenance issues may have already been corrected and that a record of these repairs may not exist as some repair requests are done verbally without a written record into a maintenance log. As per the worksheets, loose bed rails were identified for 44 bed systems. Broken bed rails were noted for three bed systems. A new remote was needed for five bed systems. On one of the five bed systems requiring a new remote it was noted that the foot of the bed could no longer be elevated. Mattress braces had gone missing from the head and/or the foot of the bed on approximately 11 bed systems. PSW #109 stated that mattress braces are used to prevent the mattress from slipping out of position. They further indicated that mattresses were noted to be too big as they did not fit into the braces or would not fit into braces if they were present. Mattresses were noted as being too big on 15/51 bed systems.

During a telephone interview, PSW #109 indicated that that morning, the maintenance issues identified on 18 bed systems had been corrected. PSW #109 indicated that it had been determined that bed decks were adjustable, and the noted issue of mattresses that were too big had been resolved for five bed systems. PSW #109 indicated that some mattress braces had been found in the housekeeping room that day and PSW #109 indicated that missing braces had been replaced on three bed systems. PSW #109 indicated that loose bed rails had been tightened on 15 bed systems. The home planned on continuing with repairs over subsequent days until it could be verified that all of the maintenance issues identified in January 2018 had been addressed.

Seven of the bed systems missing braces were Invacare CS Series bed systems. The manufacturer references the braces as mattress keeper rods. The user manual for these bed systems specifies "Warning: (Risk of Injury or Damage) By securing the mattress in place, the mattress keeper rods prevent unsafe gaps from forming between the bed ends or rails and the mattress. Install the mattress keeper rods correctly to decrease the risk of patient entrapment". For six of the seven bed systems missing mattress keeper rods, it was noted that the mattress was too big. For four of the CS series bed systems with both mattress keepers rods, it was noted that the mattress was too big. Bed rails were in place on all of the bed systems. Further related to mattress keepers and the mattress size, the user manual specifies "Patient ENTRAPMENT with Assist Rail or Assist Bar may cause injury or death. Mattress must fit snugly within the mattress keepers to prevent resident entrapment…"

Three of the bed systems missing braces were Basic American Metal Product bed systems. The worksheets noted that the mattresses were "OK, unless braces applied".

It was determined that there was 25 Invacare CS Series bed systems in use in the home. The Invacare CS series bed system user manual, as provided by the home, outlined the requirement for an annual maintenance program.

It was determined that there was 13 MC Health Care Products bed systems in use in the home. The user manual for these bed systems, as provided by the manufacturer, outlined a maintenance program that is to occur every six months to ensure proper functioning of the bed.

It was determined that there was three Basic American Metal Products bed systems in use in the home. The user manual as provided by the home, outlined a three month inspection program for side rails, a six month maintenance inspection program for electrical components and an annual maintenance inspection program for mechanical components.

Therefore, the licensee has failed to ensure that procedures are developed and implemented to ensure that resident bed systems are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

The severity of the issues identified was determined to be a level 2, in that there was the potential for actual harm. The scope of the issues identified was widespread, at level 3. The home had a compliance history of 2 in that it has one or more unrelated non-compliances in the last 36 months. [s. 90. (2) (a)] (733)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 17, 2019

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, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12nd day of September, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JESSICA LAPENSEE (133) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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