Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 5, 4 May 14, 2012	2012_072120_0030	Critical Incident

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

WEST OAK VILLAGE
2370 THIRD LINE, OAKVILLE, ON, L6M-4E2

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Staff Educator, Environmental Services Supervisor, Registered and non-registered staff regarding a Critical Incident.

During the course of the inspection, the inspector(s) made observations of the resident's bed system, reviewed the resident's clinical records and the home's policies and procedures on the use of restraints, evaluating bed entrapment zones and reviewed a bed inspection report conducted by an outside contractor.(H-002525-11)

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

Personal Support Services

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) 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 subsections:

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

Findings/Faits saillants :

[O. Reg. 79/10, s. 15(1)(b)] The licensee of the home did not ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In 2011 an identified resident was found lying in bed in an unsafe position involving a raised bed rail. They assisted the resident and reported the incident to the registered nurse. The resident was assessed by a doctor on the same day and did not have any treatable injuries. As a temporary safety measure, the bed rails were secured to prevent their use on the date of the incident and removed from the bed a few days later.

The resident's bed system was evaluated in 2011 by a representative from a bed manufacturer. Health Canada's Guidelines titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Reliability and Other Hazards" was used to establish whether entrapment zones existed. The identified resident's bed failed 3 zones of entrapment, one of them being zone 4, the area under the rail at both ends of the rail due to poor mattress compressability. According to Health Canada's guidelines, factors that may increase the gap size are: mattress compressibility, lateral shift of the mattress or rail, and degree of play from loosened rails and that the space poses a risk for entrapment of a patient's neck due to improper mattress fit and compressability. During the inspection, it was observed that the mattress moved laterally and was slightly narrower than the bed frame.

The home did not take any steps or mitigation measures between the audit date and the date of the incident, a total of 19 days to eliminate bed rail entrapment risks to the resident.

Approximately 20 new electric beds with no entrapment risks were delivered to the home in February 2012. These beds were allocated to residents at the time who were at high risk of falls and for those who require bed rails. However, the identified resident did not receive one of these beds.

Confirmation was made with the Administrator and the Director of Care that there are still many residents who use bed rails and sleep on mattresses that have failed compressability standards. These mattresses and the bed frames according to the Administrator, are scheduled to be replaced over the next few years.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

[O. Reg. 79/10, s.110(7)] The licensee did not ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee did not ensure that the following were documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

On a particular date in 2011, an identified resident was restrained by the use of a bed rail on one side of their bed and a wall on the other side of their bed. The bed rail was applied twice over the course of 6 hours while the resident was in bed to prevent the resident from climbing out of bed.

Interviews with registered staff and the resident's health care records confirm that the resident did not have an order for the use of a bed rail as a physical restraint. Registered staff and a personal support worker (PSW) made a decision to use the bed rail on a particular date to keep the resident falling out of bed. The resident had become very agitated and had set off their bed alarm twice over the course of 6 hours. Progress notes made by registered staff on the date of the incident do not indicate what alternatives were considered and why those alternatives were inappropriate, the name of the person who made the order to apply the bed rail and any specific instructions related to it's use, whether the resident or their substitute decision maker gave consent to use the bed rail, the person or persons who applied the bed rail and the time of application, all assessment, reassessment and monitoring, including the resident's response, the time or times the bed rail was released and the time the bed rail was discontinued and any post-restraining care.

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 every use of a physical device to restrain a resident under section 31 of the Act is documented, to be implemented voluntarily.

WN #3: 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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)] The directions set out in the plan of care for an identified resident are not clear to staff regarding the use of bed rails.

The resident's plan of care gives staff direction that bed rails are to be used for transfers and for bed mobility. The directive was developed one month after the resident's admission in 2010 and has not changed since then. Interviews with staff and a review of the resident's health care records confirm that the resident is not able to use the bed rails and has not had any bed rails in use since 3 months prior to the incident.

2. [O. Reg. 79/10, s. 6(10)(b)] The resident's plan of care has not been reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

The identified resident was admitted to the home in 2010 at which time they were mobile and needed some transferring assistance. The resident's plan of care for mobility, dated one month after the admission date directs staff to use bed rails for transfers and for the resident to use bed rails to facilitate the resident's own bed mobility. Between the admission date and one year later, the resident's mobility status deteriorated and they could no longer use their bed rails. According to nursing staff, the resident has not been able to use bed rails since approximately one year after their admission and the monitoring flow sheets completed by personal support workers show that the resident has had no bed rails in use since September 2011. The plan of care has not been updated or revised in the area of bed rail use.

The plan of care for the identified resident was also not updated when care needs change regarding their wheelchair and seat belt use. A Physicians order was made for the resident to receive a seat belt restraint in 2011, however the plan of care was not updated until 2 months after the order was received. Several registered staff recall the resident being in a wheelchair as a primary mode of locomotion 4 months prior to the appearance of the information on the resident's plan of care. The plan of care was not revised at least every six months and at any other time when the resident's care needs change in relation to wheelchair and seat belt usage.

Issued on this 28th **day of** May, **2012**

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

B. Smith

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 :	2012_072120_0030
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Apr 5, & May 14, 2012
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	WEST OAK VILLAGE 2370 THIRD LINE, OAKVILLE, ON, L6M-4E2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DIANE FITZPATRICK

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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that steps are taken to prevent resident entrapment and other safety issues related to the use of bed rails. The plan shall detail specifically the following:

1. How the risks identified by audits or assessments will be prioritized. Include time lines for replacement of the mattresses and or bed systems.
2. The types of strategies that are to be implemented to ensure residents do not become injured or restrained by bed rails, poor mattress condition or falls from bed.
3. Include with the plan, a copy of a current policy and procedure with respect to on-going bed safety assessments (which includes preventive maintenance for both bed frame and mattress) and resident needs assessments for bed type, mattress type and bed rail use.

The plan shall be implemented.

The plan shall be submitted to Bernadette Susnik, LTC Homes Inspector, Ministry of Health and Long Term Care, Performance and Improvement and Compliance Branch, 119 King St. W, 11th Floor, Hamilton, ON L8P 4Y7 by June 29, 2012. Fax: 905-546-8255 E-mail: Bernadette.Susnik@Ontario.ca

Grounds / Motifs :

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

In 2011 an identified resident was found lying in bed in an unsafe position involving a raised bed rail. They assisted the resident and reported the incident to the registered nurse. The resident was assessed by a doctor on the same day and did not have any treatable injuries. As a temporary safety measure, the bed rails were secured to prevent their use on the date of the incident and removed from the bed a few days later.

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Confirmation was made with the Administrator and the Director of Care that there are still many residents who use bed rails and sleep on mattresses that have failed compressability standards. These mattresses and the bed frames according to the Administrator, are scheduled to be replaced over the next few years. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 29, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

Issued on this 28th day of May, 2012

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

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

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