Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 7, 2014	2014_189120_0050	H-000665-14	Follow up

Licensee/Titulaire de permis

1508669 ONTARIO LIMITED
c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1

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

WEST PARK HEALTH CENTRE
103 Pelham Road, St Catharines, ON, L2S-1S9

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 29, 2014

An inspection (2014-189120-0022) was previously conducted on April 15, 2014, at which time Order #002 was issued for non-compliance related to bed safety. During this follow-up inspection, the conditions that were identified in the Order were not met. See below for further details.

Discussions were also held regarding the home's plans to date to secure the elevator and doors in the lowest level of the home where resident activities take place. The administrator reported that contractors had completed their assessments of the elevator and door systems and funds had been allocated to install the various hardware required. No specific dates for completion of the work were available.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Supervisor, registered staff and maintenance staff.

During the course of the inspection, the inspector(s) toured the first and second floors, observed beds, tested bed rails, reviewed resident assessments, residents' plan of care, bed maintenance policy and bed entrapment audit records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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

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

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

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, that steps were taken to prevent resident entrapment, taking into consideration, all potential zones of entrapment. An Order was previously issued on May 7, 2014 for the licensee to mitigate any risks to residents who slept in a bed that failed one or more entrapment zones. The Order was not complied with at the time of the follow-up inspection on July 29, 2014.

The licensee commissioned an external contractor to complete a bed safety audit on October 9, 2013 which revealed that over 80% of their bed systems failed one or more zones of entrapment. Residents were assessed by registered staff for bed rail need and use on March 25, 2014. Twenty-three residents on the 1st floor and twenty-five residents on the 2nd floor were identified as needing one or more bed rails for mobility, repositioning or other reasons. Some resident bed rails were tied down if a particular side was assessed as not needed. According to various staff members who were interviewed, no physical changes to the beds had been made since the bed safety audit in 2013. Many of the beds had also been moved from room to room and mattresses changed. Several beds were replaced with beds from storage that had never been tested. The original bed safety audit did not include a bed identifier other than a room number and the position of the bed within the room (bed 1, 2, 3 or 4). The bed safety audit could not be used as a valid guide to determine which beds passed or failed as it did not include a bed serial number or a unique identifier that was fixed to the bed frame. Home staff did not have a bed measuring tool to determine whether a bed had unacceptable gaps between the mattress and bed rail.

During the inspection on July 29, 2014, more than 50% of the beds were observed to have one bed rail elevated. Three residents who were observed sleeping in bed did not have any gap reducing interventions in place. All of the beds equipped with three-quarter length rails were identified in October 2013 as failing at least 3 out of the 4 entrapment zones. When resident rooms were toured, residents in 3 identified rooms were sleeping in their beds with one or both of the three-quarter length bed rails in the elevated position. No rail pads, gap fillers or bolsters were instituted to reduce the gaps. Beds were assessed in two identified rooms by pushing down on the mattresses under the elevated three-quarter rails. Due to the style of bed rail and type of foam mattress, a large gap formed with little pressure under the rail. For the beds where bed rails were elevated without residents in bed, according to some staff, the bed rails were left in the elevated position so that a resident could use it if they returned to bed throughout the day. This information was however not identified in the

resident's plan of care or instructions posted in most of the wardrobes regarding bed rail use.

Formal staff education had not been provided regarding entrapment zones, bed rail use and following specific care plan instructions. [s. 15(1)(b)]

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. 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 did not ensure that procedures were implemented to ensure that electrical and non-electrical equipment, specifically beds were kept in good repair and maintained at a level that met manufacturer specifications.

The home was equipped with both mechanical and non-mechanical bed systems that had not been inspected in 2013 or 2014 with respect to manufacturer's minimum required expectations for maintenance and safety. As a minimum, specific bed parts were required to be checked annually by the bed manufacturer. On April 15, 2014, 6 beds had loose rotating assist rails. The maintenance department was not aware of the issue. Post inspection, the bed supplier was contacted and the bed rails were assessed. Parts were ordered, however to date, the bed rails have not been addressed. According to the maintenance person for the home, bed disrepair issues were brought to their attention via maintenance requests made by nursing staff. No proactive maintenance checks were completed of the beds according to either the home's policy #1158 titled "Resident Room Beds" or the bed manufacturer's recommendations. [s. 90(2)(a)]

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 procedures are implemented for the home's bed systems so that they are kept in good repair and maintained at a level that meets manufacturer's specifications, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
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. 5.	CO #001	2014_323130_0003	120

Issued on this 7th day of August, 2014

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

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 :	2014_189120_0050
Log No. / Registre no:	H-000665-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 7, 2014
Licensee / Titulaire de permis :	1508669 ONTARIO LIMITED c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1
LTC Home / Foyer de SLD :	WEST PARK HEALTH CENTRE 103 Pelham Road, St Catharines, ON, L2S-1S9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARJORIE MOSSMAN

To 1508669 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_189120_0022, 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 shall take steps to mitigate resident entrapment which shall include but is not limited to the following as a minimum;

1. Ensure that all bed rails remain in the lowered position unless otherwise needed by the resident as assessed by an interdisciplinary team as per the US Food and Drug Administration's "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings, 2003".
2. Update the "Extendicare Bedrail Device Assessment Survey" that was completed in March 2014 and continue to make necessary changes to the document as residents' needs change or residents vacate or exchange beds. Fully complete the columns, specifically the column related to the interventions or actions taken to reduce entrapment.
3. Bed rail use shall be communicated to personal support workers by identifying which side of the bed the rail will be used, the number of rails that will be used, when the bed rails are to be used and the reason. If the bed has failed any zones of entrapment, the communication shall identify what specific interventions are to be applied.
4. Residents who have been assessed as requiring a bed rail that has not passed entrapment zones 1-4, shall have a suitable accessory to minimize the identified entrapment zone. For zones that cannot be mitigated in any way, the resident shall be provided with a bed that has passed all 4 entrapment zones.
5. Re-assess all bed systems using the measuring guidelines under Health Canada's "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" and document the results of the audit for future review.
6. Educate all nursing staff and personal support workers regarding the Health Canada guidelines.

The above actions shall be complied with by September 30, 2014. Contact the Inspector at least 2 weeks prior should any extensions be required.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, that steps were taken to prevent resident entrapment, taking into consideration, all potential zones of entrapment. An Order was previously issued on May 7, 2014 for the licensee to mitigate any risks to residents who slept in a bed that failed one or more entrapment zones. The Order was not complied with at the time of the follow-up inspection on July 29, 2014.

The licensee commissioned an external contractor to complete a bed safety audit on October 9, 2013 which revealed that over 80% of their bed systems failed one or more zones of entrapment. Residents were assessed by registered staff for bed rail need and use on March 25, 2014. Twenty-three residents on the 1st floor and twenty-five residents on the 2nd floor were identified as needing one or more bed rails for mobility, repositioning or other reasons. Some resident bed rails were tied down if a particular side was assessed as not needed. According to various staff members who were interviewed, no physical changes to the beds had been made since the bed safety audit in 2013. Many of the beds had also been moved from room to room and mattresses changed. Several beds were replaced with beds from storage that had never been tested. The original bed safety audit did not include a bed identifier other than a room number and the position of the bed within the room (bed 1, 2, 3 or 4). The bed safety audit could not be used as a valid guide to determine which beds passed or failed as it did not include a bed serial number or a unique identifier that was fixed to the bed frame. Home staff did not have a bed measuring tool to determine whether a bed had unacceptable gaps between the mattress and bed rail.

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Formal staff education had not been provided regarding entrapment zones, bed rail use and following specific care plan instructions. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 7th day of August, 2014

Signature of Inspector /
Signature de l'inspecteur :

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

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