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
Mar 6, 13, 2013	2013_189120_0015	H-000054-13	Critical Incident System

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

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

THE WOODLANDS OF SUNSET
920 PELHAM STREET, WELLAND, ON, L3C-1Y5

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 System inspection.

This inspection was conducted on the following date(s): February 15, 2013

Critical Incident M617-000002-13

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care and Associate Director of Resident Care regarding bed safety.

During the course of the inspection, the inspector(s) toured several resident rooms and observed the bed systems in place, reviewed a bed safety audit report and a draft bed safety policy and procedure.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 of a long-term care home has not ensured 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.

A critical incident report was submitted by the home in January 2013 indicating that a resident was found by a staff member with their right lower limb wedged between their air mattress and the right raised bed rail. It was reported that the right bed rail was not padded and that the resident sustained a minor injury which was treated in the home. Confirmation was made during the inspection that the resident's former air mattress had been replaced with a new foam mattress with raised sidewalls and a pad had been applied to the right bed rail. The resident had originally been provided with an air mattress in mid 2012 for pressure relief. The air mattress itself was designed without side re-enforced walls or side bolsters to minimize edge compressability. The resident's plan of care directs staff to raise both full rails while the resident is in bed for safety and the directive has been in place since 2007. The resident was assessed to be at high risk for falls and the application of the rails was considered a safety measure.

The resident did not receive a full assessment to determine if her bed system (bed frame, mattress and bed rails) was appropriate for her changing needs. The resident was mobile at the time of admission and deteriorated over time to become immobile. The intervention for the use of the bed rails did not change and no other options trialled or applied over the last 6 years. Progress notes made by staff for the resident state that they favored their left side and that they had pushed their legs through the opening of their left bed rail in the past. It is assumed that the left bed rail was padded for this reason, however management staff were not able to confirm which staff member applied the bed rail pad and therefore could not verify the reasons for it's application.

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was mobile at the time of admission and deteriorated over time to become immobile. The intervention for the use of the bed rails did not change and no other options trialled or applied over the last 6 years. Progress notes made by staff for the resident state that she favored her left side and that she had pushed her legs through the opening of her left bed rail in the past. It is assumed that the left bed rail was padded for this reason, however management staff were not able to confirm which staff member applied the bed rail pad and therefore could not verify the reasons for it's application.

The home currently has not assessed any residents to determine if the bed system they currently sleep on is appropriate for their needs. Existing assessment tools available to staff at the home are related to transfers and overall mobility and not specifically geared to bed safety. Bed safety assessments would require review of residents for sleep habits and patterns, the sleep environment, mobility in bed, cognition, communication, continence, risk of falls, medication and underlying medical conditions.

The home currently has a mix of bed frame models from the same manufacturer and mattresses ranging in age from 1-10 years. Five residents use therapeutic air mattresses and the other 116 sleep on foam mattresses of varying ages. The administrator provided documentation that the beds were all assessed by a bed manufacturer on September 15, 2011 to determine compliance with Health Canada's "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". The entrapment zones, if not managed, become areas where bodily parts can become lodged and trapped. The audit identified that more than 98% of the beds failed the bed entrapment zones between the rail and mattress. The home's air mattresses were not tested as they automatically fail the zones of entrapment based on their design.

Steps taken to date to reduce resident entrapment where bed rails are used have not been applied to any of the beds. These would include but not limited to the use of bolsters, gap fillers, wedges, new or alternative mattresses, padded bed rails, mattress keepers, bed rail accessories, modification to bed rails or not using bed rails. [s. 15. (1) (a)]

Additional Required Actions:

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

Issued on this 13th day of March, 2013

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

B. Susnik

Ontario

Ministry of Health and Long-Term Care

Ministére 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

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 :	2013_189120_0015
Log No. / Registre no:	H-000054-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 6, 13, 2013
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF NIAGARA 2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7
LTC Home / Foyer de SLD :	THE WOODLANDS OF SUNSET 920 PELHAM STREET, WELLAND, ON, L3C-1Y5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BRENT KERWIN

To THE REGIONAL MUNICIPALITY OF NIAGARA, 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) (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, submit and implement a plan to ensure steps are being taken to prevent resident entrapment and other safety issues related to the use of bed rails. The plan shall;

1. Identify what immediate interventions have been implemented to date to mitigate risks to residents that use one or more bed rails for beds that failed any zone of entrapment. This includes all beds, whether the mattress is foam based or not.
2. Identify what long term measures will be implemented to ensure beds continue to pass all zones of entrapment and the time lines.
3. Identify how residents are being assessed to determine if their bed system (rail, mattress and frame) are appropriate for their needs.
4. Summarize how or when staff have been or will be trained and oriented with respect to bed safety.
5. Include a copy of the home's finalized bed safety policy and procedures.

The plan and a copy of the home's bed safety policy shall be submitted to Bernadette Susnik, LTC Homes Inspector, either by mail or e-mail to 119 King St. E., 11th Floor, Hamilton, ON, L8P 4Y7 or Bernadette.susnik@ontario.ca by April 15, 2013.

Note: If an extension of the compliance date is required, please contact the Inspector at least one week before expiration of the original compliance date.

Grounds / Motifs :

1. The licensee of a long-term care home has not ensured that where bed rails are used,

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right bed rail was not padded and that the resident sustained a minor injury which was treated in the home. Confirmation was made during the inspection that the resident's former air mattress had been replaced with a new foam mattress with raised sidewalls and a pad had been applied to the right bed rail. The resident had originally been provided with an air mattress in mid 2012 for pressure relief. The air mattress itself was designed without side re-enforced walls or side bolsters to minimize edge compressability. The resident's plan of care directs staff to raise both full rails while the resident is in bed for safety and the directive has been in place since 2007. The resident was assessed to be at high risk for falls and the application of the rails was considered a safety measure.

The resident did not receive a full assessment to determine if her bed system (bed frame, mattress and bed rails) was appropriate for her changing needs. The resident was mobile at the time of admission and deteriorated over time to become immobile. The intervention for the use of the bed rails did not change and no other options trialled or applied over the last 6 years. Progress notes made by staff for the resident state that they favored their left side and that they had pushed their legs through the opening of their left bed rail in the past. It is assumed that the left bed rail was padded for this reason, however management staff were not able to confirm which staff member applied the bed rail pad and therefore could not verify the reasons for it's application.

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become areas where bodily parts can become lodged and trapped. The audit identified that more than 98% of the beds failed the bed entrapment zones between the rail and mattress. The home's air mattresses were not tested as they automatically fail the zones of entrapment based on their design.

Steps taken to date to reduce resident entrapment where bed rails are used have not been applied to any of the beds. These would include but not limited to the use of bolsters, gap fillers, wedges, new or alternative mattresses, padded bed rails, mattress keepers, bed rail accessories, modification to bed rails or not using bed rails. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2013

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.

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

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 6th day of March, 2013

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