Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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119 rue King Ouest 11iém étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 19, 2016	2016_189120_0025	0018412, 0018413, 021032, 021033-15	Follow up

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

GRACE MANOR
45 Kingknoll Drive BRAMPTON ON L6Y 5P2

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): May 4 & 5, 2016

An inspection (2015-275536-0009) was previously conducted April 23-May 8, 2015 at which time 8 Orders were issued for non-compliance related to the resident-staff communication and response system, bed systems, type of and use of physical devices, access to hazardous substances, infection prevention and control program, medication storage and staff training in various direct care programs. For this follow-up inspection, 4 of the Orders were reviewed for compliance. One Order regarding bed safety remained outstanding and the other 3 were returned to compliance. See below for further details.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Associate Director of Care, RAI-MDS Co-ordinator, Environmental Services Supervisor, registered staff and maintenance staff.

During the course of the inspection, the inspector(s) toured the home, including all tub/shower rooms, soiled and clean utility rooms, random resident bedrooms and washrooms, reviewed the home's policies and procedures related to bed safety, hazardous substances, cleaning/disinfection of communal equipment, storage of personal hygiene products and reviewed staff education attendance records for bed safety, infection prevention and control and hazardous substances.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #003	2015_275536_0009	120
LTCHA, 2007 S.O. 2007, c.8 s. 86. (2)	CO #001	2015_275536_0009	120
O.Reg 79/10 s. 91.	CO #004	2015_275536_0009	120

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

WN #1: The Licensee has failed to comply with 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, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), all residents who use one or more bed rails are to be evaluated by an interdisciplinary team, over a period of time while in bed to determine safety risks associated with bed rail use. To guide the assessor, a series of questions would be completed to determine whether the bed rail(s) are a safe device for residents while fully awake or while they are asleep. The guideline also emphasizes the need to document clearly whether alternative interventions were trialled before bed rails were implemented and if the interventions were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, cognition, behaviours, medication use, mobility and any involuntary movements, falls risks, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed), environmental factors and the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or their Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to why one or more bed rails were

required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified in the above guideline. According to the licensee's policy titled "Bed Rails" date February 5, 2016, a questionnaire was to be completed by the Registered Nurse (RN) titled "Bed System Assessment" on their computer system for each resident. Verification was made that the "Bed System Assessment" was completed for all residents, however the questions and processes identified in the prevailing practices identified above were not fully included. The licensee's policy identified that at the conclusion of the assessment, the nurse would "determine, based on the assessment, whether the bed rail was a restraint or a PASD (Personal Assistance Services Device). No reference was made in the policy regarding a conclusion of potential risk and how to ensure that the bed rail was safe for the resident in their assessed condition. The only reference made to bed safety hazards in the policy fell under section (c) directing the RN to discuss with the resident or their SDM the risks associated with the bed rails. According to the designated bed safety lead and registered staff member and Director of Care, neither were aware of the guideline and was therefore not fully incorporated into their process of reviewing hazards associated with bed rail use. [s. 15. (1) (a)]

2. The licensee did not ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Residents #101 and #102 had a therapeutic air mattress on their bed frames at the time of inspection. One resident was assessed in August 2015 and the other in April 2016 and both assessments concluded that they each required the application of both of their quarter bed rails while in bed. The reasons given were to prevent the resident from rolling out of bed or for repositioning. Both beds were observed on May 4, 2016 and confirmed to have a therapeutic air mattress on each bed and one quarter rail elevated on the right side of both residents' beds. According to the bed entrapment auditor and recorded results for both beds on April 13, 2016, neither bed passed entrapment zones 2-4. The measurement was repeated by a maintenance person on May 4, 2016 with the same conclusion. No bed accessories were observed on or around the elevated bed rails and confirmation was made by the bed safety lead involved in assessing the residents that no accessories had been implemented. According to the "Bed Safety Assessment", section #3, beds with therapeutic air mattresses were not tested for zones of entrapment and

therefore section 3B was not completed to determine what actions or steps were necessary to reduce or mitigate the zones of entrapment. Discussion was held with the bed safety lead that the questionnaire needed revisions and that all residents using a therapeutic air mattress would require safety interventions as the beds typically fail one or more entrapment zones due to their soft design. Preventative steps were therefore not taken to mitigate the zones of entrapment for residents #101 and #102. [s. 15. (1) (b)]

Additional Required Actions:

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

Issued on this 19th day of May, 2016

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2016_189120_0025
Log No. / Registre no:	0018412, 0018413, 021032, 021033-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 19, 2016
Licensee / Titulaire de permis :	HOLLAND CHRISTIAN HOMES INC 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	GRACE MANOR 45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER DYKSTRA

To HOLLAND CHRISTIAN HOMES INC, 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: 2015_275536_0009, 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 complete the following:

1. Develop or enhance the home's existing "Bed System Assessment" to include additional questions and guidance related to bed safety hazards found in the prevailing practices identified by Health Canada in a document titled “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003”.
2. An interdisciplinary team shall assess all residents using the comprehensive and amended bed safety assessment tool and document the results and recommendations for each resident who uses bed rails for any reason and update the resident's written plan of care if necessary.
3. Ensure that where residents who have been provided with a therapeutic air mattress and who require the use one or more bed rails be provided with appropriate accessories to mitigate any identified safety hazards including entrapment risks and and institute a monitoring program that will ensure that residents who require accessories to reduce any identified entrapment zones will continue to be provided with those accessories.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), all residents who use one or more bed rails are to be evaluated by an interdisciplinary team, over a period of time while in bed to determine safety risks associated with bed rail use. To guide the assessor, a series of questions would be completed to determine whether the bed rail(s) are a safe device for residents while fully awake or while they are asleep. The guideline also emphasizes the need to document clearly whether alternative interventions were trialled before bed rails were implemented and if the interventions were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, cognition, behaviours, medication use, mobility and any involuntary movements, falls risks, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed), environmental factors and the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or their Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified in the above guideline. According to the licensee's policy titled "Bed Rails" date February 5, 2016, a questionnaire was to be completed by the Registered Nurse (RN) titled "Bed System Assessment" on their computer system for each resident. Verification was made that the "Bed System Assessment" was completed for all residents, however the questions and processes identified in the prevailing practices identified above were not fully included. The licensee's policy identified that at the conclusion of the assessment, the nurse would "determine, based on the assessment, whether

the bed rail was a restraint or a PASD (Personal Assistance Services Device). No reference was made in the policy regarding a conclusion of potential risk and how to ensure that the bed rail was safe for the resident in their assessed condition. The only reference made to bed safety hazards in the policy fell under section (c) directing the RN to discuss with the resident or their SDM the risks associated with the bed rails. According to the designated bed safety lead and registered staff member and Director of Care, neither were aware of the guideline and was therefore not fully incorporated into their process of reviewing hazards associated with bed rail use. (120)

2. The licensee did not ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Residents #101 and #102 had a therapeutic air mattress on their bed frames at the time of inspection. One resident was assessed in August 2015 and the other in April 2016 and both assessments concluded that they each required the application of both of their quarter bed rails while in bed. The reasons given were to prevent the resident from rolling out of bed or for repositioning. Both beds were observed on May 4, 2016 and confirmed to have a therapeutic air mattress on each bed and one quarter rail elevated on the right side of both residents' beds. According to the bed entrapment auditor and recorded results for both beds on April 13, 2016, neither bed passed entrapment zones 2-4. The measurement was repeated by a maintenance person on May 4, 2016 with the same conclusion. No bed accessories were observed on or around the elevated bed rails and confirmation was made by the bed safety lead involved in assessing the residents that no accessories had been implemented. According to the "Bed Safety Assessment", section #3, beds with therapeutic air mattresses were not tested for zones of entrapment and therefore section 3B was not completed to determine what actions or steps were necessary to reduce or mitigate the zones of entrapment. Discussion was held with the bed safety lead that the questionnaire needed revisions and that all residents using a therapeutic air mattress would require safety interventions as the beds typically fail one or more entrapment zones due to their soft design. Preventative steps were therefore not taken to mitigate the zones of entrapment for residents #101 and #102. (120)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

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
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 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
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 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
Inspection de sions de longue durée
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
Inspection de sions de longue durée
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 19th day of May, 2016

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