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 soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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 5, 2017	2017_627138_0012	003068-17	Resident Quality Inspection

Licensee/Titulaire de permis

Kemptville District Hospital
2675 Concession Road P.O. Bag 2007 KEMPTVILLE ON K0G 1J0

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

KEMPTVILLE DISTRICT HOSPITAL
2675 CONCESSION ROAD P. O. BAG 2007 KEMPTVILLE ON K0G 1J0

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

PAULA MACDONALD (138), MICHELLE JONES (655)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 25, 26, 27, and 28, 2017.

During the course of the inspection, the inspector(s) spoke with residents, substitute decision makers (SDMs), the Activity Coordinator, the acting Team Leader, the Team Leader, a registered dietitian, registered practical nurses (RPNs), personal care assistants (PCAs), food service workers (FSWs), volunteers, a physiotherapist (PT), the Maintenance Team Leader, and the Vice President of Nursing and Clinical Services.

The inspectors also conducted a review of the health care records, toured residential and non residential areas, observed meal services, observed a medication administration, reviewed Resident's Council Meeting minutes, and reviewed the home's restraint policy.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

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 failed to ensure that where bed rails are used, 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.

On August 21, 2012, a notice was issued to Long-Term Care Home Administrators from the Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the notice, it is written that this HC Guidance Document is expected to be used "as a best practice document".

The HC Guidance Document characterizes, where bed rails are used, the body parts at risk for entrapment (head, neck, chest), identifies the locations of bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes testing methods for assessing gaps in bed systems.

The HC Guidance Document also includes the titles of two additional companion documents by the Hospital Bed Safety Workgroup (HBSW) established by the Food and Drug Administration (FDA) in the United States. One of the companion documents is titled “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings” (Companion Document) (HBSW, US FDA, 2003). This document provides necessary guidance in establishing a

clinical assessment where bed rails are used.

In the Companion Document, it is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, in order to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including (but not limited to) alternative interventions trialed and the resident's medical needs, cognition, mobility, sleep habits and patterns, sleep environment, resident comfort in bed, and potential safety concerns. There must be clear documentation of this risk-benefit analysis in the residents' health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

On April 25, 2017, Inspector #655 observed the bed system belonging to resident #002. At that time, Inspector #655 observed there to be a gap between the inside surface of the footboard and the end of the mattress, large enough to allow the inspector to insert two hands into the space. On April 26 and April 28, 2017, the same gap between the inside surface of the foot board and the end of the mattress was observed. At the time of these observations, it was also noted that there were four useable, ¼ length, bed rails attached to resident #002's bed system.

In the HC Guidance document, the space between the inside surface of the footboard and the end of the mattress is identified as one of the seven areas in a bed system where there is a potential for entrapment, and is referred to as Zone 7. According to the HC Guidance Document, Zone 7 may present a risk of head entrapment when taking into account such factors as mattress compressibility, any shift of the mattress, and any degree of play from a loosened headboard or footboard.

Inspector #655 reviewed the health care record belonging to resident #002. According to the Resident Care Kardex, two bed rails were in use by resident #002.

On review of the health care record, Inspector #655 was unable to locate any documentation that would demonstrate that resident #002 had been assessed for bed rail use; or that the bed system belonging to resident #002 had been evaluated in accordance with prevailing practices, in order to minimize risk to the resident.

During an interview on April 26, 2017, PCA #100 indicated to Inspector #655 that two short (¼) bed rails are to be placed in the up position for resident #002 when the resident

is in bed at night. During the same interview, PCA #100 acknowledged that there was a gap between the inside surface of the footboard and the end of the mattress of the bed system belonging to resident #002. At that time, PCA #100 indicated to Inspector #655 that because resident #002 has a tendency to slide down toward the end of the bed, a rolled-up blanket is inserted into the gap at the end of the bed, when the resident is in bed at night.

During interviews on April 26, 2017, neither RPN #101 or RPN #106, or the acting Team Leader, were able to speak to a process for ensuring that where bed rails are used, the resident is assessed and the bed system is evaluated in accordance with prevailing practices.

During an interview on April 27, 2017, the Vice President of Nursing and Clinical Services indicated to Inspector #655 that all bed systems in the home were evaluated for safety, including entrapment zone testing, by the manufacturer prior to their arrival to the home; but not since. The Vice President of Nursing and Clinical Services indicated to Inspector #655 that there is no process in place for evaluating resulting new bed systems when a change is made to a bed system, such as when a bed rail or mattress is replaced.

In the HC Guidance Document, it is recognized that older bed systems (i.e. legacy beds) have the potential for dimensional change over time, through wear and tear or replacement of its parts, such as the installation of a new mattress. It is further indicated in the HC Guidance Document, that where a bed no longer has its original mattress, it may present an entrapment risk by increasing spaces, or creating new gaps between the various components of the bed system (i.e. a foot board or bed rail, for example).

Inspector #655 reviewed a "Purchase Data" document provided to the Inspector by Maintenance Team Leader #109. According to the "Purchase Data" document, the bed system belonging to resident #002 (Serial # F075AB2914, Asset/Bed # 739) was purchased in March, 2004 and received by the home on March 29, 2004. During an interview on April 28, 2017, Maintenance Team Leader #109 confirmed the same. The bed system belonging to resident #002, therefore, had not been evaluated since 2004.

Moreover, during an interview on April 28, 2017, the Team Leader indicated to Inspector #655 that mattresses in the home are typically replaced on an as-needed basis. According to the Team Leader, the condition of each mattress is assessed each time there is a new admission. If the mattress is observed to have considerable wear and tear, it is replaced before the incoming resident uses the bed system. The Team Leader was

unable to speak to a process for tracking such changes to a bed system. The Team Leader indicated, however, that approximately two years ago, several mattresses were replaced when the home received a large order of new mattresses. On observing the mattress that was in place on resident #002's bed system at the time of the inspection, the Team Leader indicated that resident #002's mattress was one of those mattresses that was received approximately two years ago; and therefore the mattress on resident #002's bed system was replaced within the last two years. The Team Leader was unable to speak to a process for ensuring that any resulting new bed systems are evaluated in accordance with prevailing practices. When a new mattress was installed on the bed system belonging to resident #002, the resulting new bed system was not evaluated in accordance with prevailing practices.

The licensee failed to ensure that resident #002 was assessed prior to the use of bed rails; and, failed to ensure that the bed system belonging to resident #002 was evaluated, in accordance with prevailing practices, to minimize risk to the resident.

Over the course of the inspection, it was noted that residents #001, #003, and #004 also used bed rails. Inspector #655 and Inspector #138 were unable to locate any documentation to indicate that any of these residents had been assessed for the use of bed rails; nor that their bed systems had been evaluated in accordance with prevailing practices at any time after their arrival to the home.

As the non-compliance described above is widespread, and presents the potential for harm (risk of entrapment) to the residents, a compliance order will be served on the licensee. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to comply with section 26. (3) 5. of the Regulation in that the licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behaviour triggers and variations in resident functioning at different times of the day.

Inspector #138 spoke with RPN #101 regarding the use of antipsychotic medication for resident #003. RPN #101 stated that resident #003's behaviours are controlled and that the antipsychotic medication has been discontinued. RPN #101 described resident #003's behaviours and RPN #101 reported the interventions in place. RPN #101 stated that these intervention have been effective for the behaviours.

Inspector #138 reviewed the health care record for resident #003 and noted that the antipsychotic medication was discontinued. The inspector further reviewed the health care record including the plan of care as defined by the acting Team Leader as the Resident Care Kardex, the Individual Plan of Care, and the Medication Administration

Record (MAR) but noted that the plan of care did not outline resident's #003 described behaviours nor the interventions in place to manage these behaviours. [s. 26. (3) 5.]

2. The licensee failed to comply with section 26. (3) 16. of the Regulation in that the licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of activity patterns and pursuits.

Inspector #138 reviewed the health care record for resident #003. The last Minimum Data Set (MDS) quarterly review available was reviewed and this MDS quarterly review outlined that resident #003 was identified with concerns related to personal pursuits. The inspector reviewed the available monthly activity statistics on the health care record and noted concerns with the resident's activities attendance. Inspector #138 spoke with the Activation Coordinator who identified the same concerns.

Inspector #138 further reviewed resident #003's plan of care. It was noted by the inspector that the plan of care for the resident did not include activity pattern and pursuits, including any identified concerns with the activity pattern and pursuits. [s. 26. (3) 16.]

3. The licensee failed to comply with section 26. (4) (a) of the Regulation in that the licensee failed to ensure that a registered dietitian who is a member of the staff of the home completes a nutritional assessment for all residents on admission and whenever there is significant change in the resident's health condition.

Inspector #138 reviewed the health care record for resident #002 related to a nutritional concern. The inspector noted that the resident was admitted to the home on a specified date, however, the initial nutritional assessment was not completed by the registered dietitian until fifty seven days later, at which time the resident was identified by the registered dietitian to be at nutritional risk.

Inspector #138 also reviewed the health care record for resident #003 which, again, was also related to a nutritional concern. The inspector noted that the resident was admitted on a specific date, however, the initial nutritional assessment was not completed by the registered dietitian until almost a month later.

Inspector #138 spoke with the registered dietitian who confirmed that the initial nutritional assessments for resident #002 and resident #003 were not completed on admission. [s. 26. (4) (a),s. 26. (4) (b)]

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 1) to ensure that the plan of care for resident #003 is based on an interdisciplinary assessment of a) the resident's mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behaviour triggers and variations in resident function at different times of the day and b) the resident's activity pattern and pursuits and 2) to ensure that the registered dietitian completes the initial nutrition assessment on admission, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is restrained by a physical device, the restraining of the resident is included in the resident's plan of care.

On January 17, 2017, resident #001 was admitted to a long-term care bed with a variety of diagnosis. At the time of the inspection, resident #001 had cognitive impairment.

On April 25 and again on April 26, 2017, Inspector #655 observed resident #001 to have a physical device in place. On April 26, 2017, resident #001 was unable to undo the physical device when asked to do so by Inspector #655.

Over the course of the inspection, PCA # 100, PCA #103, and PT #111 indicated to Inspector #655 that resident #001 was incapable of undoing the physical device.

During an interview on April 26, 2017, PCA #100 indicated to Inspector #655 that a physical device is applied at all times whenever resident #001 is in a specific position. PCA #100 indicated to Inspector #655 that resident #001 has specific risks; and for this reason, the physical device is used. During the same interview, PCA #100 indicated to Inspector #655 that PCA staff are expected to refer to the Resident Care Kardex for information related to a resident's plan of care, including information related to the use of a restraint. PCA #100 reviewed resident #001's Resident Care Kardex with Inspector #655 present. PCA #100 was unable to locate any information related to the use of physical device as a restraint for resident #001 in the Resident Care Kardex.

During an interview on April 26, 2017, RPN #101 indicated to Inspector #655 that where a resident is restrained by a physical device it is expected that there would be an order and consent for the use of the restraint. During the same interview, RPN #101 indicated to Inspector #655 that registered nursing staff would likely document that the resident was wearing a physical device in the progress notes. Inspector #655 reviewed the progress notes for the period of time time and was unable to locate any documentation related to the use of a physical device for resident #001.

During an interview on April 27, 2017, PT # 111 reviewed the health care record belonging to resident #001 and was unable to locate an order or a documented consent for the use of the physical device as a restraint for resident #001.

During an interview on April 27, 2017, the acting Team Leader indicated that she was also unable to locate any documentation that would demonstrate that consent had been obtained for the use of a physical device as a restraint in resident #001s health care record. At the same time, the acting Team Leader confirmed that there was no order for the use of the physical device as a restraint for resident #001. The acting Team Leader explained that resident #001 had experienced a cognitive decline since the physical device had originally been implemented. According to the acting Team Leader, when the resident was no longer capable of removing the physical device, it would have been the responsibility of registered nursing staff to ensure that an order was obtained.

Inspector #655 reviewed the health care record belonging to resident #001. With the exception of an “Admission Assessment and History”, on which it was identified that a physical device was already in use for resident #001 at the time of admission; Inspector #655 was unable to locate any documentation related to the use of the physical restraint as a restraint for resident #001. There was no information related to the use of a physical device by resident #001 on the resident's plan of care. Neither an order nor documented

consent for the physical device could be located by Inspector #655.

The licensee failed to ensure that when resident #001 was restrained by a physical device, the restraining of the resident was included in the resident's plan of care. [s. 31. (1)]

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 the use of a restraint for resident #001 is included in the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 71. (1) (b) of the Regulation in that the licensee failed to ensure that the home's menu cycle includes menus for regular, therapeutic and texture modified diets for both meals and snacks.

Inspector #138 observed the lunch dining service on April 25, 2017. The Inspector spoke with FSW #102 about specialized diets in the home and the FSW stated to the inspector that most residents received regular diets except for two residents who were to receive soft diets.

Inspector #138 spoke with FSW #102, FSW #105, and the registered dietitian about the soft diets. It was determined that the home did not have a menu to support the soft diet nor was there an individualized menu for either of the two residents receiving a soft diet to guide serving staff in ensuring appropriate foods were offered to these residents. Further, there were inconsistencies in discussions with FSW #102, FSW #105, and the registered dietitian regarding appropriate foods to be served to residents requiring a soft diet. [s. 71. (1) (b)]

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 the home's menu cycle includes menus for all texture modified diets, to be implemented voluntarily.

WN #5: 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:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to comply with section 6. (4) (b) of the Act in that the licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Resident #002 was identified with a nutritional concern over two months. The home's registered dietitian assessed resident #002 and initiated a nutritional intervention for the nutritional concern. The plan of care was updated to include the nutritional intervention and an order for the nutritional intervention was transcribed by the registered dietitian in the physician's orders the same day as the assessment. There was no subsequent documentation to indicate that the nutritional intervention was ever discontinued.

Inspector #138 reviewed the medication administration record (MAR) for the two months for resident #002 and noted that the MARs did not contain any information or direction about the nutritional intervention that was to be initiated on the day of the registered dietitian's assessment. Inspector #138 spoke with RPN #101 regarding the nutritional intervention and she stated that these types of nutritional interventions would be documented in the MARs. RPN #101 reviewed the MARs for resident #002 and stated that resident #002 was not currently receiving this nutritional intervention.

Inspector #138 spoke with resident #002 and the resident reported not receiving the specified nutritional intervention. The inspector observed the resident later that day, on April 26, 2017, and noted that the resident was not provided the nutritional intervention has had been planned through the registered dietitian's assessment.

Inspector #138 spoke with the registered dietitian regarding nutritional interventions. The registered dietitian stated that the food service department will ensure supplies but that the nursing staff is responsible to provide the nutritional interventions to the residents. The registered dietitian confirmed that resident #002 was to have a specific nutritional intervention and also confirmed that it had not been discontinued. The registered dietitian was unable to explain why resident #002 had not received the nutritional intervention as order in the assessment. [s. 6. (4) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 27. (1) (a) of the Regulation in that the licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision maker (SDM).

Resident #003 was admitted to the home with multiple diagnosis. Inspector #138 spoke with resident #003's SDM regarding the initial care conference that is to be held within six weeks of admission and the resident's SDM stated that no such care conference had occurred since admission.

Inspector #138 reviewed resident #003's health care record and was unable to locate any documentation that demonstrated that a care conference was held for the resident since admission to the home. Inspector #138 spoke with the acting Team Leader regarding the home's process for care conference within six weeks of admission. The acting Team Leader reported that the home would hold a care conference for a resident if necessary and that the care conference would be documented in the progress notes if it occurred. Inspector #138 reviewed the progress notes for resident #003 since admission and was unable to locate any documentation that a care conference was held for the resident. [s. 27. (1)]

Issued on this 5th day of May, 2017

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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PAULA MACDONALD (138), MICHELLE JONES (655)
Inspection No. / No de l'inspection :	2017_627138_0012
Log No. / Registre no:	003068-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 5, 2017
Licensee / Titulaire de permis :	Kemptville District Hospital 2675 Concession Road, P.O. Bag 2007, KEMPTVILLE, ON, K0G-1J0
LTC Home / Foyer de SLD :	KEMPTVILLE DISTRICT HOSPITAL 2675 CONCESSION ROAD, P. O. BAG 2007, KEMPTVILLE, ON, K0G-1J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Burke

To Kemptville District Hospital, 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) (a)

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 is ordered to:

1. Evaluate all bed systems where bed rails are used in the home, in accordance with evidence-based practices; and ensure that the results of each bed system evaluation are documented.

2. Establish and implement a process for ensuring that any bed system failures are addressed immediately by taking the necessary corrective actions, in accordance with prevailing practices. All actions taken to address bed system failures are to be documented.

3. Ensure that when any modification is made to a bed system with bed rails in use (such as a change of mattress or bed rail, or the addition of an accessory), the resulting new bed system is evaluated, in accordance with evidence- based practices; and the results of the new bed system evaluation are documented.

4. Develop and implement a documented interdisciplinary team assessment process for all residents with one or more bed rails in use (including partial rails), and for all residents for which the use of one or more bed rails is being considered. The process shall include an individual resident assessment and shall specifically include all factors, elements and conditions as outlined in the

prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (HBSW, FDA, 2003). As well, the process shall consider the general guidance outlined within the Treatment Programs/Care Plans section of the FDA 2003 clinical guidance document.

5. Ensure that the interdisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes which may serve as an alternative to bed rail use; and, that the interventions or changes are trialed if appropriate, and dependent on the resident assessment, during a specified observation period prior to the application of any bed rails or prior to the removal of any bed rails.

6. Ensure that the interdisciplinary team reassesses residents with one or more bed rails in use, at a minimum, whenever there is a change in the residents' health status.

7. Ensure that the interdisciplinary team clearly documents the final results of the resident assessment or reassessment, including the risk-benefit analysis and ensuing recommendation(s).

8. Update the written plan of care based on the assessment or reassessment of the resident by the interdisciplinary team. Include all required information as specified in the FDA 2003 clinical guidance document.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails are used, 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.

On August 21, 2012, a notice was issued to Long-Term Care Home Administrators from the Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the notice, it is written that this HC Guidance Document is expected to be used "as a best practice document".

The HC Guidance Document characterizes, where bed rails are used, the body parts at risk for entrapment (head, neck, chest), identifies the locations of bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes testing methods for assessing gaps in bed systems.

The HC Guidance Document also includes the titles of two additional companion documents by the Hospital Bed Safety Workgroup (HBSW) established by the Food and Drug Administration (FDA) in the United States. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (Companion Document) (HBSW, US FDA, 2003). This document provides necessary guidance in establishing a clinical assessment where bed rails are used.

In the Companion Document, it is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, in order to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including (but not limited to) alternative interventions trialed and the resident's medical needs, cognition, mobility, sleep habits and patterns, sleep environment, resident comfort in bed, and potential safety concerns. There must be clear documentation of this risk-benefit analysis in the residents' health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

On April 25, 2017, Inspector #655 observed the bed system belonging to resident #002. At that time, Inspector #655 observed there to be a gap between the inside surface of the footboard and the end of the mattress, large enough to allow the inspector to insert two hands into the space. On April 26 and April 28, 2017, the same gap between the inside surface of the foot board and the end of the mattress was observed.

In the HC Guidance document, the space between the inside surface of the footboard and the end of the mattress is identified as one of the seven areas in a bed system where there is a potential for entrapment, and is referred to as Zone 7. According to the HC Guidance Document, Zone 7 may present a risk of head entrapment when taking into account such factors as mattress compressibility,

any shift of the mattress, and any degree of play from a loosened headboard or footboard.

At the time of the above-noted observations, it was also noted that there were four useable, ¼ length, bed rails attached to resident #002's bed system.

Inspector #655 reviewed the health care record belonging to resident #002. According to the Resident Care Kardex, two bed rails were in use by resident #002.

On review of the health care record, Inspector #655 was unable to locate any documentation that would demonstrate that resident #002 had been assessed for bed rail use; or that the bed system belonging to resident #002 had been evaluated in accordance with prevailing practices, in order to minimize risk to the resident.

During an interview on April 26, 2017, PCA #100 indicated to Inspector #655 that two short (¼) bed rails are to be placed in the up position for resident #002 when the resident is in bed at night. During the same interview, PCA #100 acknowledged that there was a gap between the inside surface of the footboard and the end of the mattress of the bed system belonging to resident #002. At that time, PCA #100 indicated to Inspector #655 that because resident #002 has a tendency to slide down toward the end of the bed, a rolled-up blanket is inserted into the gap at the end of the bed, when the resident is in bed at night.

During interviews on April 26, 2017, neither RPN #101 or RPN #106, or the acting Team Leader were able to speak to a process for ensuring that where bed rails are used, the resident is assessed and the bed system is evaluated in accordance with prevailing practices.

During an interview on April 27, 2017, the Vice President of Nursing and Clinical Services indicated to Inspector #655 that all bed systems in the home were evaluated for safety, including entrapment zone testing, by the manufacturer prior to their arrival to the home; but not since. The Vice President of Nursing and Clinical Services indicated to Inspector #655 that there is no process in place for evaluating resulting new bed systems when a change is made to a bed system, such as when a bed rail or mattress is replaced.

In the HC Guidance Document, it is recognized that older bed systems (i.e.

legacy beds) have the potential for dimensional change over time, through wear and tear or replacement of its parts, such as the installation of a new mattress. It is further indicated in the HC Guidance Document, that where a bed no longer has its original mattress, it may present an entrapment risk by increasing spaces, or creating new gaps between the various components of the bed system (i.e. a foot board or bed rail, for example).

Inspector #655 reviewed a "Purchase Data" document provided to the Inspector by Maintenance Team Leader #109. According to the "Purchase Data" document, the bed system belonging to resident #002 (Serial # F075AB2914, Asset/Bed # 739) was purchased in March, 2004 and received by the home on March 29, 2004. During an interview on April 28, 2017, Maintenance Team Leader #109 confirmed the same. The bed system belonging to resident #002, therefore, had not been evaluated since 2004.

Moreover, during an interview on April 28, 2017, the Team Leader indicated to Inspector #655 that mattresses in the home are typically replaced on an as-needed basis. According to the Team Leader, the condition of each mattress is assessed each time there is a new admission. If the mattress is observed to have considerable wear and tear, it is replaced before the incoming resident uses the bed system. The Team Leader was unable to speak to a process for tracking such changes to a bed system. The Team Leader indicated, however, that approximately two years ago, several mattresses were replaced when the home received a large order of new mattresses. On observing the mattress that was in place on resident #002's bed system at the time of the inspection, the Team Leader indicated that resident #002's mattress was one of those mattresses that was received approximately two years ago; and therefore the mattress on resident #002's bed system was replaced within the last two years. The Team Leader was unable to speak to a process for ensuring that any resulting new bed systems are evaluated in accordance with prevailing practices. When a new mattress was installed on the bed system belonging to resident #002, the resulting new bed system was not evaluated in accordance with prevailing practices.

The licensee failed to ensure that resident #002 was assessed prior to the use of bed rails; and, failed to ensure that the bed system belonging to resident #002 was evaluated, in accordance with prevailing practices, to minimize risk to the resident.

Over the course of the inspection, it was noted that residents #001, #003, and #004 also used bed rails. Inspector #655 and Inspector #138 were unable to locate any documentation to indicate that any of these residents had been assessed for the use of bed rails; nor that their bed systems had been evaluated in accordance with prevailing practices at any time after their arrival to the home.

As the non-compliance described above is widespread, and presents the potential for harm (risk of entrapment) to the residents, a compliance order will be served on the licensee.
(655)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2017

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 soins 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 soins 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 5th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PAULA MACDONALD

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