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 prévue le Loi de 2007 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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2017;	2017_627138_0022 (A1)	009018-17	Follow up

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

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 prévue le Loi de 2007 les foyers de soins de longue durée

RUZICA SUBOTIC-HOWELL (548) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home's management requested an 90 day extension to the compliance due date to ensure full compliance with the order. This extension has been granted.

Issued on this 16 day of November 2017 (A1)

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

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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

RUZICA SUBOTIC-HOWELL (548) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): September 7, 8, and 11, 2017.

This Follow up inspection related to the use of bed rails.

During the course of the inspection, the inspector(s) spoke with personal support workers, registered practical nurses (RPNs), the Manger Building Services, the Vice President of Nursing and Clinical Services, and residents.

The inspector also toured resident rooms to observe bed systems, reviewed the home's Bed Entrapment Prevention Program including the policy for bed rails and bed entrapment, and reviewed the available bed system test results.

The following Inspection Protocols were used during this inspection:

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)

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 comply with section 15.(1)(a) of the Regulation in that 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.

The following non compliance is a re-issue of Compliance Order #001 which was issued May 5, 2017, from the Resident Quality Inspection, Inspection No. 2017_627138_0012, Log No 003068-17. This non compliance is widespread and presents the potential for harm (risk of entrapment) to the residents.

As previously stated in Compliance Order #001 from the Resident Quality Inspection, a notice was issued to Long-Term Care Home Administrators from the Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch on August 21, 2012, 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 trailed 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 resident's 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.

Inspection #138 entered the home on September 7, 2017, and met with the Vice President of Nursing and Clinical Services to discuss actions taken by the home to address Compliance Order #001 that was issued on May 5, 2017, from the Resident Quality Inspection. The Vice President of Nursing and Clinical Services provided the inspector with a copy of the home's Bed Entrapment Prevention Program. The inspector reviewed the program noting that the program referenced the HC Guidance Document as well as the companion documents, that it included a policy titled "Bed Rails and Bed Entrapment", and that it included a Bed Rail Consent form, a Bed Rail Risk Assessment form, and a Bed System Measurement Device Test Results Worksheet. The Vice President of Nursing and Clinical Service stated that nursing is responsible for the individualized resident assessments related to the use of bed rails including the Bed Rail Consent form and the Bed Rail Risk Assessment form whereas Building Services is responsible for the Bed System Measurement Device Test Results Worksheet and the testing of the bed systems for potential entrapment areas.

On September 8, 2017, Inspector #138 viewed the bed systems in the twelve

resident rooms and observed that bed rails were in the up position for the bed systems belonging to residents #002, #004, #005, #006, #007, #008 and #009.

Inspector #138 reviewed the health care records for the residents listed above. The inspector was unable to locate an individualized resident assessment related to the use of bed rails for each of these residents. The inspector spoke with RPN #101 about the individualized resident assessment related to the use of bed rails and RPN #101 stated that she was aware of such assessment but that the practice of completing such assessment has not yet been implemented.

Inspector #138 then had another discussion with the Vice President of Nursing and Clinical Services who stated that the development of the Bed Entrapment Prevention Program was a large project and also confirmed that the program was not yet fully implemented, providing various rationale as to why it was not fully implemented.

Inspector #138 returned to resident #004's room for further observation of the resident's bed system. It was noted by the inspector that there was a gap between the inside surface of the foot board and the end of the mattress, large enough to allow the inspector to insert two hands, side by side, into the space. At the time of these observations, it was also noted that there were four usable bed rails attached to resident #004's bed system with one of the rails at the head in the up position.

In the HC Guidance document, the space between the inside surface of the foot board 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 head board or foot board.

Inspector #138 spoke with the Manager Building Services regarding the testing of bed systems for potential entrapment areas. The Manager Building Services stated that the since the issuance of Compliance Order #001 from the Resident Quality Inspection, a testing tool for bed systems has been purchased, maintenance staff have been trained to conduct the testing of bed systems for entrapment, and an inventory control system has been implemented to track the frames and the mattresses of bed systems. The Manager Building Services provided the inspector with the results of the bed system testing completed thus far

as documented on a Bed System Measurement Device Test Results Worksheet. The inspector reviewed the worksheets, noting that there were only testing results for three of the twelve beds system, though all three bed systems passed the test. The Manager Building Services confirmed that not all the twelve bed systems have been tested and also confirmed that the bed system in resident #004's room has not yet been tested. The Manager Building Services stated that she would arrange to have resident #004's bed system evaluated that day.

The licensee failed to ensure that individualized resident assessments were completed for residents using bed rails. The licensee also failed to ensure that all bed systems with bed rails were evaluated, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

Issued on this 16 day of November 2017 (A1)

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

Ministère 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : RUZICA SUBOTIC-HOWELL (548) - (A1)

Inspection No. / No de l'inspection : 2017_627138_0022 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 009018-17 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Nov 16, 2017;(A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère 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

To Kemptville District Hospital, 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: 2017_627138_0012, CO #001;

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. Resident #004's bed system shall be evaluated immediately.

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. Implement the documented interdisciplinary team assessment process that has been developed by the home 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 trialled 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 comply with section 15.(1)(a) of the Regulation in that 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.

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bed, and potential safety concerns. There must be clear documentation of this risk-benefit analysis in the resident's 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.

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Ontario

Ministry of Health and Long-Term Care

Ministère 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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le :

Mar 01, 2018(A1)

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16 day of November 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RUZICA SUBOTIC-HOWELL - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère 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

Service Area Office / Bureau régional de services : Ottawa