Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
September 8 & 13, 2010	2010_167_2975_08Sep102415 2010_127_2975_07Sep164606	Other related to Critical Incident Report # H-01266

Licensee/Titulaire

St. Joseph's Health System, 56 Governor's Road, Dundas, Ontario, L9H 5G7

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

St. Joseph's Villa, 56 Governor's Road, Dundas, Ontario, L9H 5G7

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

Marilyn Tone – Long Term Care Homes Inspector - Nursing #167

Richard Hayden – Long Term Care Homes Inspector - Environmental Health #127

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an inspection related to a Critical Incident Report

During the course of the inspection, the inspectors spoke with: The Administrator, the Director of Care, a Nursing Manager, the Registered Nurse and the two Personal Support Workers who had knowledge of the incident.

During the course of the inspection, the inspectors reviewed the health records for the resident involved in the incident, reviewed the home's investigation notes and witness statements, reviewed the equipment in use at the time of the incident, reviewed the home's policies and procedures related to restraint usage and alternatives to restraints as well as the falls risk program and interviewed the management and staff who were present or had knowledge of the incident.

The following Inspection Protocols were used during this inspection:

- Minimizing of Restraints inspection Protocol
- Critical incident Inspection Protocol
- Hospitalization and Death inspection Protocol
- Safe and Secure Home Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

10 WN
9 VPC
1 CO

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN # 1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8. 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.

Findings:

In 2010, an identified resident became trapped in the bedrails of the bed. The bed was noted to have four split bedrails raised at the time of the incident. The resident's plan of care did not address or include the use of bedrails. The resident had a history of climbing out of bed. The bedrails were not used by the resident to assist in routine activities of daily living and therefore are a restraint.

Inspector ID #:	# 167

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if a resident is restrained that it is included in the resident's plan of care, to be implemented voluntarily.

WN # 2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 31(2)1, 2, 4, 5. The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

1) There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
4) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: The restraining of the resident has been consented to by the resident or, if

the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Findings:

1) No assessment was conducted related to significant risk prior to the application of four raised bedrails on an identified resident's bed.
2) No assessment was completed indicating that alternatives to restraint that had been considered and tried where appropriate and found to be ineffective. The progress notes in an identified resident's health file indicate that the resident was sometimes placed in a chair during the night for closer monitoring and on the night of the incident it was confirmed by the staff having knowledge of the incident that there was a fall mat present on the floor beside the resident's bed and that four split bedrails were elevated. Neither of these interventions was present on the resident's plan of care.
3) There was no physician's order or order by a registered nurse in the extended class or other person provided for in the regulations present on an identified resident's health file for the use of four bedrails on the resident's bed.
4) The home did not obtain consent from an identified resident's substitute decision-maker prior to the application of four raised bedrails when the resident was in bed.

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Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents using restraints have been assessed for use of restraint including alternatives tried, that there is an order for the use of the restraint by the physician or the nurse practitioner, that the resident's plan of care gives clear direction to staff related to the use of the restraint and that consent is obtained for restraint use to be implemented voluntarily.

WN # 3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(1)(c). Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

1) The plan of care for an identified resident did not identify the number of bedsides to be used when the resident was in bed.
2) There were no interventions noted on the resident's plan of care related to management of the resident's agitation at night and the subsequent risk for falls. For example, the progress notes indicate that when the resident was restless at night staff have gotten the resident into a chair to prevent climbing out of the bed. This intervention has not been entered in to the resident's written plan of care.
3) The use of the falls mat that was in use at the bedside of the resident was not incorporated in to the resident's written plan of care.

Inspector ID #:	# 167

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby

requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each residents gives clear direction to staff and others providing care, to be implemented voluntarily.

WN # 4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(11)(b). When a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

Findings:

An identified resident climbed out of bed nine times in 2010. There was no reassessment of the resident's plan of care related to falls from the bed or different approaches considered to address this concern.

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Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents' plans of care are reviewed and revised when the plan of care has not been effective, to be implemented voluntarily.

WN # 5: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(2). The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Findings:

The resident was not assessed related to the falls that she was experiencing during the night.
The plan of care for an identified resident did not identify the number of bedsides to be used when the resident was in bed or the use of the fall mat that was being placed bedside the resident's bed. There were no interventions noted on the resident's plan of care related to management of the resident's agitation at night and the subsequent risk for falls. For example, the progress notes indicate that when the resident was restless at night, staff have gotten the resident into a chair to prevent climbing out of bed. This information has not been entered in to the resident's plan of care.

Inspector ID #:	167

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident's plan of care is based on an assessment of the resident's needs and preferences, to be implemented voluntarily.

WN # 6: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(7). The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:

The plan of care related to risk of injury from falls for an identified resident dated 2010 directs staff to observe resident hourly for safety. Staff did not observe or monitor the resident between 0230 and 0500 on the night when the incident occurred as directed in the resident's plan of care.

Inspector ID #:	# 167

Additional Required Actions

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care specified in the resident's plan of care is provided to the resident, to be implemented voluntarily.

WN # 7: The Licensee has failed to comply with O. Reg. 79/10, s. 110(2)3. Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

Findings:

Despite the use of restraints (four raised bedsides on an identified resident's bed) no hourly monitoring took place between 0230 and 0500 on the night when the incident occurred.

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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 all residents that are being restrained by a physical device are monitored at least every hour, to be implemented voluntarily.

WN # 8: The Licensee has failed to comply with O. Reg. 79/10, s. 26(3)5. A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 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.

Findings:

The plan of care for an identified resident did not specially address the resident's agitation at night and the frequent episodes of resident climbing out of bed at night. There were no interventions present on the resident's plan of care to address this concern.

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Additional Required Actions:
VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's plan of

care is based on an interdisciplinary assessment of mood and behaviour patterns, any identified responsive behaviours, any potential triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN # 9: The Licensee has failed to comply with O. Reg. 79/10, s. 8(1) a. Where the Act or this Regulation requires the Licensee of the long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

a) is in compliance with and is implemented in accordance with all applicable requirements under the Act,

Findings:

1) The home's policy and procedure related to the use of restraints and alternatives to restraints has not been updated to reflect the current legislation. (e.g. The policy did not address the use of PASDs or the type of bedrails that are currently being used in the home).
2) The home's falls prevention and management program has not been updated to comply with O.Reg.79/10 s.49 related to strategies to reduce and mitigate falls including monitoring of residents, review of the resident's drug regime or post fall protocols.
3) The home's policy and procedure related to reporting of Critical Incidents has not been updated to reflect current legislation. The current policy does not give clear direction to staff related to the required timelines for mandatory reporting of specific types of incidents.

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Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policies, protocols, procedures, strategies or systems related to the use of PASDs and bedrails, falls prevention and reporting of critical incidents is in compliance with all applicable requirements of the Act, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O. Reg. 79/10, s. 15(1)(a) and (b). 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.

Findings:

1. Four bed rails were in the raised and locked position while an identified resident was in bed overnight in 2010. Staff did not check on the resident for more than 2 hours while these restraints were in place.
2. No indication that an identified resident was assessed for bed rail use.
3. No indication that there was an order for bed rail use in the care of an identified resident.
4. No indication that there was consent for bed rail use in the care of an identified resident.
5. As per Health Canada's Guidance Document entitled *Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards*, the following zones of bed rail entrapment risk were identified on an identified resident's bed and no steps were taken to prevent the resident from becoming

entrapped:

- Zone 1 spaces were greater than 120 mm
- Zone 2 spaces were greater than 120 mm
- Zone 4 spaces were greater than 60 mm

Inspector ID #:	# 127

Additional Required Actions:

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

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Revised for the purpose of publication. Written assigned Aug 5/11 for TM Dore
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Richard Hayden	**Inspector ID #**	127
Log #:	H-01266		
Inspection Report #:	2010_167_2975_08Sep102415 2010_127_2975_07Sep164606		
Type of Inspection:	Critical Incident		
Date of Inspection:	September 8 & 13, 2010		
Licensee:	St. Joseph's Health System 56 Governor's Road, Dundas, Ontario, L9H 5G7		
LTC Home:	St. Joseph's Villa 56 Governor's Road, Dundas, Ontario, L9H 5G7		
Name of Administrator:	Shawn Gadsby		

To St. Joseph's Health System, you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: O. Reg. 79/10, s. 15(1)(a) and (b).
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;

Order:

The licensee, St. Joseph's Health System, shall:

1. prepare a plan for achieving compliance to ensure that all residents with bedrails in use at the long-term care home, municipally known as St. Joseph's Villa, 56 Governor's Road, Dundas, Ontario are 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 residents and to ensure steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment;

2. submit a copy of this plan to Inspector: Richard Hayden, Ministry of Health and Long-Term Care, Hamilton Service Area Office, 119 King Street West, 11th Floor, Hamilton ON L8P 4Y7; and
3. implement the plan for achieving compliance at the long-term care home, municipally known as St. Joseph's Villa, 56 Governor's Road, Dundas, Ontario.

Grounds:

1. Four bed rails were in the raised and locked position while an identified resident was in bed overnight in 2010.
2. The identified resident was not assessed for bed rail use.
3. Bed rail use was not ordered in the care of the identified resident.
4. No consent was granted for bed rail use in the care of the identified resident.
5. As per Health Canada's Guidance Document entitled *Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards*, the following zones of bed rail entrapment risk were identified on the identified resident's bed and no steps were taken to prevent the resident from becoming entrapped:
   - Zone 1 spaces were greater than 120 mm
   - Zone 2 spaces were greater than 120 mm
   - Zone 4 spaces were greater than 60 mm

This order must be complied with by:	**21 December 2010**

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 service for the Licensee.

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

Director
c/o Appeals Clerk

Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board **and the**
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 6th day of December, 2010.	
Signature of Inspector:	Mare signed for Richard Hayden (Revised for the purpose of publication)
Name of Inspector:	Richard Hayden
Service Area Office:	119 King Street West, 11th Floor, Hamilton ON L8P 4Y7