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 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

Hamilton Service Area Office
119 King Street West 11th Floor
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 30, 2019	2019_539120_0007 (A2)	005415-18, 005420-18	Follow up

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

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

St. Joseph's Lifecare Centre
99 Wayne Gretzky Parkway BRANTFORD ON N3S 6T6

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

Amended by BERNADETTE SUSNIK (120) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due date for compliance order #002 was extended from May 31, 2019, to June 30, 2019.

Issued on this 30th day of May, 2019 (A2)

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

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

Ministère de la Santé et des Soins de longue durée

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

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

Amended by BERNADETTE SUSNIK (120) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 6 & 8, 2019

An inspection (2018-587129-0001) was previously conducted in January 2018, related to door access control systems in the home and resident clinical assessments where bed rails were used. Two compliance orders were issued (#001 and #003) in February 2018. For this follow-up visit, the conditions in both compliance orders were not fully met and are being re-issued.

During the course of the inspection, the inspector(s) spoke with the interim President, Assistant Director of Care, Director of Care, Restorative Coaches, administrative staff, registered staff, personal support workers and maintenance person.

During the course of the inspection, the inspector toured various home areas, observed resident bed systems, tested stairwell doors and a public entry door for function and connectivity to the resident-staff communication and response system, reviewed resident bed safety assessments and their clinical records and bed safety policies and procedures.

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

During the course of the original inspection, Non-Compliances were issued.

2 WN(s)
0 VPC(s)
2 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	Légende 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that doors that led to a stairway and doors that led to the outside of the home were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and connected to the resident-staff communication and response system.

An inspection was previously conducted in January 2018, related to door access control systems in the home. Compliance order #003, was issued in February

2018, with the following requirements to be complied with by the end of November 2018:

1. Connect all doors that are between any non-residential LTC resident areas to public areas or areas used by non-LTC staff, the main foyer door, stairwell doors and the door located between the public area and the LTC home side on the fourth floor to the resident-staff communication and response system.
2. All of the doors listed in #1 above shall have an audible door alarm at the door that can be cancelled only at the point of activation (at the door).
3. Develop a written policy and procedure that deals with when doors to balconies shall be locked and unlocked. The policy and procedure shall be implemented.
4. Develop a procedure for designated staff to include regular and routine door checks to their routines to ensure doors to balconies, stairwells, nonresidential areas and the outside are locked. The procedure shall be implemented.
5. All staff shall be oriented to the above required policies and procedures and documentation shall be kept as to who received the orientation, when it was given and by whom.

During this follow up inspection, requirements #1(partial), #2, #3, #4 and #5 remained outstanding.

I) On the first date of inspection, a public entrance door to the long term care home was confirmed to have been equipped with a back up door alarm. However, the door alarm was not functioning properly or was cancelled at a point away from the door. The sliding glass door did not alarm after blocking it from closing for more than seven minutes. After consulting with maintenance staff #003, it was discovered that the alarm was disconnected by a desk clerk who was stationed at a desk near the entry door. The desk was equipped with a remote switch to either turn the alarm off or on and also to cancel it when activated. When the desk switch was turned on and the sliding door re-tested, the back up alarm sounded at the three minute mark. However, the door was kept open by staff #003 at it's widest point. Staff #003 stated that the doors were set to alarm at three minutes, and identified the small magnetic sensors that were connected to the alarm system. Discussion was held with staff #003 regarding the placement of the sensors and their function if the sliding door was impeded half way along it's path.

Two days later, the public entrance door was tested again and failed to alarm after four minutes. The desk clerk was present when tested and it was assumed

that the alarm had not been switched off. Two portable phones that personal support workers (PSW) were required to carry, were also tested to determine if the door, when it failed to close, would display the location of the door breach on the phone display screen. Neither of the portable phones (0203, 0204), which were a component of the resident-staff communication and response system, activated in any way to the door breach. The door was therefore not equipped with an audible door alarm that allowed the calls to be cancelled only at the point of activation (door) and was not connected to the resident-staff communication and response system.

II) A door to a stairwell heavily used by LTC staff was confirmed to have been equipped with a back up door alarm. However, the alarm did not activate when held open for more than three minutes. When other stairwell doors were tested, the alarm sounded after 40 seconds. Neither of the portable phones used above activated when the door was held open for more than three minutes. The stairwell door was therefore not equipped with an audible door alarm that allowed the calls to be cancelled only at the point of activation (door) and was not connected to the resident-staff communication and response system. A discussion was held with maintenance staff #003 and the President of the LTC home during the inspection regarding how to establish the ideal programmed delay times on various door types as no specific delay times were legislated.

III) The portable phones used by PSWs, to alert them to an active station (either resident bedside, bathroom or common area) sounded when tested in one resident room on an identified home area. Portable phones identified as #1201 and #1202 in the home area did not sound when the stairwell door next to the nurse's substation was tested, but a visual display of the breached door was accurately displayed. Portable phones identified as #0101 and #0103 in a different home area did not sound when a stairwell was tested. According to several PSWs, their phones routinely sounded when they received a signal from activated stations in resident rooms. The sound would prompt them to look at the display. However, if no sound was made, the PSW would not know that an alarm had been activated. When the stairwell doors were tested in each home area, and the phones verified to be receiving the signal from the doors, the phones were silent. According to the Assistant Director of Care, when the the back up alarms were first installed and the phones tested, each phone was confirmed to have sounded and had a visual display of the location of the door breach. As per s.17(1) of O. Reg 79/10, a resident-staff communication and response system must clearly indicate when activated the location of the call and if using sound,

must be calibrated so that the level is audible to staff.

VI) With respect to requirements #3, #4 and #5, during interviews with PSWs on various home areas, they were not aware of any communication that was sent to them regarding the home's policy and procedures regarding stairwell doors, balcony doors and the main entrance door. According to the Director of Care, the required policies identified in the compliance order were not finalized and had not been disseminated. In it's place, for the short term, an email was allegedly sent to all staff. The PSWs reported that they either could not access their emails or did not have time to read them.

The licensee failed to ensure that doors that led to a stairway and doors that led to the outside of the home were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and connected to the resident-staff communication and response system. [s. 9. (1)]

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

WN #2: 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 were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection was previously conducted in January 2018, related to resident clinical assessments where bed rails were used. Compliance order #001 was issued in February 2018, with the following requirements to be complied with by the end of August 2018;

1. Amend the home's existing "Bed Entrapment and Assessment " form to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003). This document is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". The amended questionnaire shall, at a minimum, include:

a) questions that can be answered by the assessors related to the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b) the alternatives that were trialled prior to the application of one or more bed rails and document whether the alternatives were effective during the specified

period of time; and
c) include the names of the interdisciplinary team members who participated in evaluating the resident; and
d) provide clear written direction or alternative (i.e decision tree) to assist the assessor(s) in answering the questions when determining whether bed rails are a safe alternative for the resident being assessed.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed entrapment and assessment form and document the assessed results and recommendations for each resident. The assessment document is to be included in the resident's clinical record.

3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories or interventions that were required to mitigate any identified bed safety hazards.

4. Obtain or develop an education and information package that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, how beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts associated with bed systems and the use of bed rails.

5. Amend the "Medical Beds and the Potential for Resident Entrapment (5-RS-35) " policy and associated forms and procedures to include all of the above noted requirements and any additional relevant information noted in the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". All registered and non-registered staff shall be informed about the amended policy, forms and procedures.

During this follow up inspection, items #1 a, c, d, #3 and #4 were completed, and #1b, #2 and #5 remained outstanding.

With respect to #1b and #2, three residents (#101, #102, #103) were randomly selected during this inspection to determine if they were assessed for bed related

safety risks in accordance with the clinical guidelines. Restorative coaches #001 and #002 were responsible for completing the resident assessments, updating the bed safety policies and procedures, clinical assessment questionnaire and creating a sleep observation questionnaire for personal support workers (PSW). The assessments for the above three residents were determined to be missing documentation in identifying the risk over the benefits of bed rail use for residents using one or more bed rails.

The first area of documentation that was not included on the "Bed Safety Assessment" for each identified resident included; b) the alternatives that were trialled prior to the application of one or more bed rails and document whether the alternatives were effective during the specified period of time. The form included a number of interventions for the assessor to choose from such as bed alarms, falls mat, bed positioning, behaviourial interventions and other options, however no option was included related to what method or device could be used to replace a bed rail. The form did not include any space to document when and for how long the alternative was trialled for and whether it was effective or not for the resident's identified condition.

The second area of documentation that was not included on the "Bed Safety Assessment" for each identified resident included the outcome of the resident's sleep observation assessment. A statement on the form related to the sleep observation only identified that it was in the resident's chart. One question was related to the resident's sleeping patterns, but it only related to whether they slept through the night, but no direct link was made to the results of the sleep observation period (three nights). According to the restorative coaches, only those residents that were newly admitted since the compliance order was served, received a formal sleep assessment. Approximately 50-70 residents were identified to use one or more bed rails, with the majority of those being residents who did not receive a formal sleep assessment. Therefore not all residents were re-assessed as per requirement #2.

The third area of documentation that was not included on the form (or in the resident's clinical chart) was an area to document the final risk over benefit conclusion of the interdisciplinary team related to the resident and their bed system. For all three above noted residents, the assessments did not include any information about whether alternatives were trialled, whether the residents received a formal sleep assessment and what the final risk over benefit conclusion was for each resident. The overall risk status of the three identified

residents was not apparent until additional questions were asked of the restorative coaches about each resident. A conclusion was established by the restorative coaches that all residents who have not had a formal sleep observation should be re-assessed to establish current risk factors.

With respect to requirement #5, the licensee's policy and procedure titled "Medical Beds and the Potential for Resident Entrapment (5-RS-35)" did not include any reference as to what form or questionnaire would be used to assess a resident, did not reference the decision tree or bed rail minimization algorithm that was to be used, the role of the PSW in the assessment process, the sleep observation process and associated questionnaire, any direction regarding what to do when a bed system was not in good condition or who to contact if there was an entrapment or suspension incident, when to use alternatives and what alternatives were available (in place of a bed rail) or what accessories were available or strategies to mitigate any risks related to a specific bed system (as per the U.S. Food and Drug Administration's "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, June 21, 2006"). According to restorative coach #001, registered and non-registered staff (PSW), were informed about the amended policies and procedures (and associated forms and brochure) via email in August 2018, by taking a quiz in August 2018, and a formal face to face session in October 2018. Beginning in 2019, the policies were added to a computer based learning system. However, records of who attended a session or viewed their email was not known.

The licensee failed to ensure that where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended: CO# 002

Issued on this 30th day of May, 2019 (A2)

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by BERNADETTE SUSNIK (120) - (A2)
Inspection No. / No de l'inspection :	2019_539120_0007 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005415-18, 005420-18 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	May 30, 2019(A2)
Licensee / Titulaire de permis :	St. Joseph's Health System 50 Charlton Avenue East, Room M146, HAMILTON, ON, L8N-4A6
LTC Home / Foyer de SLD :	St. Joseph's Lifecare Centre 99 Wayne Gretzky Parkway, BRANTFORD, ON, N3S-6T6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	David Wormald

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 St. Joseph's Health System, 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: 2018_587129_0001, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee failed to comply with compliance order #003 from inspection #2018-587129-0001 served on February 27, 2018 with a compliance due date of November 28, 2018.

The licensee failed to complete requirements #1 (partial), #2, #3, #4 and #5 from CO #003.

The licensee must be compliant with s.9(1) of O. Reg. 79/10.

Specifically, the licensee shall complete the following:

1. Develop a written policy and procedure that deals with when doors to balconies shall be locked and unlocked. The policy and procedure shall be implemented.
2. Develop a procedure for designated staff to regularly check doors to balconies, stairwells, non-LTC home areas and the outside to determine if they are locked and alarm (where required) when left open beyond the programmed time delay. Documentation shall be maintained when any door fails to function as required and immediate action taken. The procedure shall be implemented.
3. All staff shall be oriented to the above required policies and procedures and documentation shall be kept as to who received the orientation, when it was given and by whom.
4. Disconnect any remote switches that control the alarm system for the public entrance door to the LTC home.
5. Determine the set or programmed time delay for the back up alarm (and the resident-staff communication and response system) to sound at the public entrance door and doors to stairwells and non-LTC areas. The programmed time delay for alarms at any stairwell door includes the time it takes an average person to open the door after disengaging the magnetic lock, the time it takes for the person to clear the door area and for the door to self close. An additional five seconds may also be added to the time delay, if warranted. Once determined, all doors shall be programmed accordingly. Excessive time delays are not effective as residents can easily exit several seconds after a person has used an exit door.
6. Portable phones related to the resident-staff communication and response

system shall be programmed so that they sound when a stairwell door in the specified home area for that phone remains open beyond the programmed or set time delay. For the ground floor, the main entrance door, doors to non-LTC areas and stairwell door labelled "4-0", one or both home areas on the ground floor shall have all portable phones sound when the above mentioned doors remain open beyond the programmed or set time delays.
7. Verify that the connection between the resident-staff communication and response system, including the back-up alarms and stairwell door "4-0" and the public entrance door to the LTC home are functioning as required. The public entrance door, which slides open and closed, must be designed so that an alarm sounds when prevented from closing at several points across the path of travel and not just at one point, which was identified during the inspection.

Grounds / Motifs :

1. The licensee failed to ensure that doors that led to a stairway and doors that led to the outside of the home were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and connected to the resident-staff communication and response system.

An inspection was previously conducted in January 2018, related to door access control systems in the home. Compliance order #003, was issued in February 2018, with the following requirements to be complied with by the end of November 2018:

1. Connect all doors that are between any non-residential LTC resident areas to public areas or areas used by non-LTC staff, the main foyer door, stairwell doors and the door located between the public area and the LTC home side on the fourth floor to the resident-staff communication and response system.
2. All of the doors listed in #1 above shall have an audible door alarm at the door that can be cancelled only at the point of activation (at the door).
3. Develop a written policy and procedure that deals with when doors to balconies shall be locked and unlocked. The policy and procedure shall be implemented.
4. Develop a procedure for designated staff to include regular and routine door checks to their routines to ensure doors to balconies, stairwells, nonresidential areas and the outside are locked. The procedure shall be implemented.
5. All staff shall be oriented to the above required policies and procedures and documentation shall be kept as to who received the orientation, when it was given

and by whom.

During this follow up inspection, requirements #1(partial), #2, #3, #4 and #5 remained outstanding.

I) On the first date of inspection, a public entrance door to the long term care home was confirmed to have been equipped with a back up door alarm. However, the door alarm was not functioning properly or was cancelled at a point away from the door. The sliding glass door did not alarm after blocking it from closing for more than seven minutes. After consulting with maintenance staff #003, it was discovered that the alarm was disconnected by a desk clerk who was stationed at a desk near the entry door. The desk was equipped with a remote switch to either turn the alarm off or on and also to cancel it when activated. When the desk switch was turned on and the sliding door re-tested, the back up alarm sounded at the three minute mark. However, the door was kept open by staff #003 at it's widest point. Staff #003 stated that the doors were set to alarm at three minutes, and identified the small magnetic sensors that were connected to the alarm system. Discussion was held with staff #003 regarding the placement of the sensors and their function if the sliding door was impeded half way along it's path.

Two days later, the public entrance door was tested again and failed to alarm after four minutes. The desk clerk was present when tested and it was assumed that the alarm had not been switched off. Two portable phones that personal support workers (PSW) were required to carry, were also tested to determine if the door, when it failed to close, would display the location of the door breach on the phone display screen. Neither of the portable phones (0203, 0204), which were a component of the resident-staff communication and response system, activated in any way to the door breach. The door was therefore not equipped with an audible door alarm that allowed the calls to be cancelled only at the point of activation (door) and was not connected to the resident-staff communication and response system.

II) A door to a stairwell heavily used by LTC staff was confirmed to have been equipped with a back up door alarm. However, the alarm did not activate when held open for more than three minutes. When other stairwell doors were tested, the alarm sounded after 40 seconds. Neither of the portable phones used above activated when the door was held open for more than three minutes. The stairwell door was therefore not equipped with an audible door alarm that allowed the calls to be

cancelled only at the point of activation (door) and was not connected to the resident-staff communication and response system. A discussion was held with maintenance staff #003 and the President of the LTC home during the inspection regarding how to establish the ideal programmed delay times on various door types as no specific delay times were legislated.

III) The portable phones used by PSWs, to alert them to an active station (either resident bedside, bathroom or common area) sounded when tested in one resident room on an identified home area. Portable phones identified as #1201 and #1202 in the home area did not sound when the stairwell door next to the nurse's substation was tested, but a visual display of the breached door was accurately displayed. Portable phones identified as #0101 and #0103 in a different home area did not sound when a stairwell was tested. According to several PSWs, their phones routinely sounded when they received a signal from activated stations in resident rooms. The sound would prompt them to look at the display. However, if no sound was made, the PSW would not know that an alarm had been activated. When the stairwell doors were tested in each home area, and the phones verified to be receiving the signal from the doors, the phones were silent. According to the Assistant Director of Care, when the the back up alarms were first installed and the phones tested, each phone was confirmed to have sounded and had a visual display of the location of the door breach. As per s.17(1) of O. Reg 79/10, a resident-staff communication and response system must clearly indicate when activated the location of the call and if using sound, must be calibrated so that the level is audible to staff.

VI) With respect to requirements #3, #4 and #5, during interviews with PSWs on various home areas, they were not aware of any communication that was sent to them regarding the home's policy and procedures regarding stairwell doors, balcony doors and the main entrance door. According to the Director of Care, the required policies identified in the compliance order were not finalized and had not been disseminated. In it's place, for the short term, an email was allegedly sent to all staff. The PSWs reported that they either could not access their emails or did not have time to read them.

The licensee failed to ensure that doors that led to a stairway and doors that led to the outside of the home were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and connected to the resident-staff

communication and response system.

This compliance order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. In respect to severity, there was a potential for harm (2), the scope was a pattern, (2) and the home had a level 4 history as non compliance continues in the same area of O. Reg. 79/10 that included: A compliance order (CO) issued on February 27, 2018 (2018-587129-0001)
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2019(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

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_587129_0001, 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 failed to comply with compliance order #001 from inspection #2018-587129-0001 served on February 27, 2018 with a compliance due date of August 28, 2018.

The licensee completed requirements #1 a, c, d, #3 and #4 but failed to complete requirements #1b, #2 and #5 from CO #001.

The licensee must be compliant with s.15(1) of O. Reg. 79/10.

Specifically, the licensee shall complete the following:

1. Amend the "Medical Beds and the Potential for Resident Entrapment (5-RS-35) " policy and associated forms and procedures to include the following;

a) the name of the specific form or questionnaire that is to be used to assess a resident using one or more bed rails; and

b) a reference to the decision tree or bed rail minimization algorithm that is to be used
c) the role of the PSW in the sleep observation process; and
d) the name of the specific form or questionnaire that is to be used by the PSW when conducting a sleep observation review; and
e) direction regarding what to do when a bed system is not in good condition
f) who to contact and plan of action if there is an entrapment or suspension incident, including a near miss; and
g) when to use alternatives and what alternatives are available (in place of a bed rail)
h) what accessories are available or strategies to mitigate any risks related to a specific bed system (as per the U.S. Food and Drug Administration's "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, June 21, 2006").

2. Amend the questionnaire identified as "Bed System Assessment" used to assess residents who use one or more bed rails to include the following;

a) an area to document when and for how long an alternative was trialled for and whether it was effective or not for the resident's identified condition; and
b) an area to document the final risk over benefit conclusion of the interdisciplinary team related to the resident and their bed system.

3. Re-assess all residents who use one or more bed rails that did not receive a formal sleep observation review in 2018.

4. All registered and non-registered staff (PSWs) who have not received face to face education about bed safety, the home's sleep observation process and the amended policies and procedures in 2018, shall receive face to face education by May 31, 2019. A record shall be kept of what information was provided, who provided the information, on what date(s) and who attended the session(s).

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection was previously conducted in January 2018, related to resident clinical assessments where bed rails were used. Compliance order #001 was issued in February 2018, with the following requirements to be complied with by the end of August 2018;

1. Amend the home's existing "Bed Entrapment and Assessment " form to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003). This document is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". The amended questionnaire shall, at a minimum, include:

a) questions that can be answered by the assessors related to the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b) the alternatives that were trialled prior to the application of one or more bed rails and document whether the alternatives were effective during the specified period of time; and
c) include the names of the interdisciplinary team members who participated in evaluating the resident; and
d) provide clear written direction or alternative (i.e decision tree) to assist the assessor(s) in answering the questions when determining whether bed rails are a safe alternative for the resident being assessed.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed entrapment and assessment form and document the assessed results and recommendations for each resident. The assessment document is to be included in the resident's clinical record.

3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories or interventions that were required to mitigate any identified bed safety hazards.

4. Obtain or develop an education and information package that can be made

available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, how beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts associated with bed systems and the use of bed rails.

5. Amend the "Medical Beds and the Potential for Resident Entrapment (5-RS-35) " policy and associated forms and procedures to include all of the above noted requirements and any additional relevant information noted in the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". All registered and non-registered staff shall be informed about the amended policy, forms and procedures.

During this follow up inspection, requirements #1 a, c, d, #3 and #4 were completed, and #1b, #2 and #5 remained outstanding.

With respect to #1b and #2, three residents (#101, #102, #103) were randomly selected during this inspection to determine if they were assessed for bed related safety risks in accordance with the clinical guidelines. Restorative coaches #001 and #002 were responsible for completing the resident assessments, updating the bed safety policies and procedures, clinical assessment questionnaire and creating a sleep observation questionnaire for personal support workers (PSW). The assessments for the above three residents were determined to be missing documentation in identifying the risk over the benefits of bed rail use for residents using one or more bed rails.

The first area of documentation that was not included on the "Bed Safety Assessment" for each identified resident included; b) the alternatives that were trialled prior to the application of one or more bed rails and document whether the alternatives were effective during the specified period of time. The form included a number of interventions for the assessor to choose from such as bed alarms, falls mat, bed positioning, behaviourial interventions and other options, however no option was included related to what method or device could be used to replace a bed rail. The form did not include any space to document when and for how long the alternative was trialled for and whether it was effective or not for the resident's

identified condition.

The second area of documentation that was not included on the "Bed Safety Assessment" for each identified resident included the outcome of the resident's sleep observation assessment. A statement on the form related to the sleep observation only identified that it was in the resident's chart. One question was related to the resident's sleeping patterns, but it only related to whether they slept through the night, but no direct link was made to the results of the sleep observation period (three nights). According to the restorative coaches, only those residents that were newly admitted since the compliance order was served, received a formal sleep assessment. Approximately 50-70 residents were identified to use one or more bed rails, with the majority of those being residents who did not receive a formal sleep assessment. Therefore not all residents were re-assessed as per requirement #2.

The third area of documentation that was not included on the form (or in the resident's clinical chart) was an area to document the final risk over benefit conclusion of the interdisciplinary team related to the resident and their bed system. For all three above noted residents, the assessments did not include any information about whether alternatives were trialled, whether the residents received a formal sleep assessment and what the final risk over benefit conclusion was for each resident. The overall risk status of the three identified residents was not apparent until additional questions were asked of the restorative coaches about each resident. A conclusion was established by the restorative coaches that all residents who have not had a formal sleep observation should be re-assessed to establish current risk factors.

With respect to requirement #5, the licensee's policy and procedure titled "Medical Beds and the Potential for Resident Entrapment (5-RS-35)" did not include any reference as to what form or questionnaire would be used to assess a resident, did not reference the decision tree or bed rail minimization algorithm that was to be used, the role of the PSW in the assessment process, the sleep observation process and associated questionnaire, any direction regarding what to do when a bed system was not in good condition or who to contact if there was an entrapment or suspension incident, when to use alternatives and what alternatives were available (in place of a bed rail) or what accessories were available or strategies to mitigate any risks related to a specific bed system (as per the U.S. Food and Drug Administration's "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of

Entrapment, June 21, 2006"). According to restorative coach #001, registered and non-registered staff (PSW), were informed about the amended policies and procedures (and associated forms and brochure) via email in August 2018, by taking a quiz in August 2018, and a formal face to face session in October 2018. Beginning in 2019, the policies were added to a computer based learning system. However, records of who attended a session or viewed their email was not known.

The licensee failed to ensure that where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

This compliance order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. In respect to severity, there was a potential for harm (2), the scope was a pattern, (2) and the home had a level 4 compliance history as the same area of non-compliance under 15(1) of O. Reg. 79/10 was issued and included:

*A compliance order (CO) issued on February 27, 2018 (2018-587129-0001)
*A voluntary plan of compliance (VPC) issued on February 24, 2017 (2017-558123-0016)

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2019(A2)

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:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 30th day of May, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by BERNADETTE SUSNIK (120) - (A2)

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 : Hamilton Service Area Office