Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 14, 2016 | 2016_553536_0021 | 031882-16 | Resident Quality Inspection |

## Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE BRAMPTON
7891 Mclaughlin Road BRAMPTON ON L6Y 5H8

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

CATHIE ROBITAILLE (536), THERESA MCMILLAN (526)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): November 23, 24, 25, 28, 29, 30, December 1, 2 and 6, 2016**

**The following inspections were completed concurrently with the Resident Quality Inspection.**

**Critical Incident System Report:**

**001767-16-related to: falls prevention**
**031731-16-related to: falls prevention**

**Complaints**

**031766-15-related to: prevention of abuse and neglect, skin and wound care a, responsive behaviours, hospitalization and safe and secure home**
**036422-15-related to: hospitalization and change in condition**

**During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW's), registered staff, Dietary Supervisor, Food Service Supervisor, Social Worker, Housekeeping/Laundry Supervisor, Resident Assessment Instrument-Material Data Set Co-Ordinator(RAI-MDS), Director of Care (DOC) and the Administrator.**

**During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on home areas, interviewed staff, residents and families, and reviewed relevant documents including, clinical records, investigation reports, training records, meeting minutes and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**

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

- **6 WN(s)**
- **1 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**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. 2007, c. 8, s. 6 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to 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.

A) A review was completed of resident #025's clinical record. Resident #025 was admitted into the home on an identified date. On an identified date, a care conference was held for resident #025 with their family in attendance. An interview with the family as well as the care conference notes, specified that the family expressed concerns about the resident. Following the care conference the physician ordered a specified test. The progress notes by registered staff #113 stated, that resident #025 had identified symptoms. During interview with staff #113 they confirmed that they had not done any further assessment in regards to resident #025 symptoms.On another identified date, the progress notes by registered staff #112 stated that family was in to visit and resident was complaining of pain.

A review was completed of resident #025's records. The resident demonstrated a change in condition in the days leading up to their hospitalization. A review of the home's protocol "General Guideline for Management of Hyperglycemia in Type 2 Diabetes" stated: If blood glucose test exceeds a specified level, the nursing staff should follow steps: confirm test results; assess changes in resident's status and follow facility protocol/medical directive/treatment plan including pain and report other conditions to physician: infection; acute coronary symptoms; other symptoms; and monitoring-following sick day management protocol on blood glucose testing, dietary changes and when to contact physician. Registered staff #113 confirmed that the home had a protocol for management of high blood glucose levels however, they had not implemented the protocol on that date. The plan of care for resident #025 which the home refers to as the care plan stated: "monitor and report signs of hyperglycemia i.e. extreme thirst, frequent urination, abdominal pain, fatigue, blurred vision, dry/flushed skin, shallow rapid breathing immediately.

On an identified date, the progress notes by registered staff #113 stated that the resident started the shift alert and responsive. The progress note also stated that during the identified meal that the resident had some specified symptoms, and that the resident also had to be fed their meal. On an identified date and time one of the resident's family members came in to visit. At an identified time, staff #113 received a call from the substitute decision maker (SDM) once again voicing concerns about the resident's health. As per the progress notes, registered staff went to the resident's room and asked family if they would like to send resident to the hospital and they agreed. The licensee did note ensure that care set out in the plan of care is based on an assessment of resident #025 and the needs of the resident.

B) A review was completed of resident #003's clinical record. The resident's plan of care which the home refers to as the care plan, specified that the resident had side rails to assist with bed mobility and transfers. According to resident #003's Resident Assessment Inventory Minimum Data Set (RAI MDS) assessment completed on an identified date, bed rails were noted to be in use. However, on the RAI MDS assessment dated on three other identified dates, no bed rails were coded. The RAI/MDS Coordinator confirmed that coding of the side rails had been missed on all those identified RAI MDS assessments. [s. 6. (2)]

***Additional Required Actions:***

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

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**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, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident. The "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings"(2003) had defined prevailing practices for the use of bed rails in long term care homes since 2010. The Guidelines state the following in relation to Individualized Patient Assessment when bed rails are in use for a resident: "Any decision regarding bed rail use or removal from use should be made within the framework of an individual patient assessment. If a bed

rail has been determined to be necessary, steps should be taken to reduce the known risks associated with its use. The individual patient assessment includes medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); and risk of falling.

A) During observations on an identified date, bed rails were observed at the head of the bed in the raised position of resident #002's occupied bed while an air mattress was inflated with no additional devices installed to prevent entrapment. According to resident #002's Resident Assessment Inventory Minimum Data Set (RAI MDS) assessment completed on an identified date, bed rails were noted to be in use. Registered staff #105 and personal support worker (PSW) staff #103 confirmed that the resident could move themselves in the bed. A review of the resident's clinical record and confirmation from staff #105, indicated that the resident had not been assessed for the use of bed rails. (526)

During interview, the home's Maintenance Supervisor stated that they did not include beds with air mattresses in their annual bed entrapment audit, and that resident #005's bed was not assessed since it had an air mattress in place. The home's "Bed Entrapment Worksheet", confirmed that beds with air mattress's were not assessed. Registered staff #105 and PSW staff #013 confirmed that the resident was at risk for bed entrapment if their mattress became deflated, since the resident was able to move within the bed and any potential zones of entrapment had not been assessed or steps taken to prevent resident entrapment.

B) During observations on an identified date, resident #005 was observed in bed with two half bed rails in the engaged position. According to their RAI MDS assessment completed on an identified date, bed rails were noted to be in use. Registered staff #100 stated that the resident was able to move in the bed. Upon their return from hospital, the resident was not able to get out of bed and was unable to assist with bed mobility. Between return from hospital and this inspection, their transfer and bed mobility had improved, and the resident was ambulating to their wheelchair and was assisting with turning and repositioning while in bed. In addition, according to PSW staff #100, the resident's SDM had asked for the resident's assist rails to be in the engaged position rather than the assist position.

A review of the resident's clinical record indicated that they were last assessed for the

use of bed rails on an identified. They had not been assessed since their condition changed upon return from hospital, or since a change in the use of bed rails from the assist position to the engaged position. (526)

C) During observations on an identified date, bed rail where observed on resident #003's bed. One rail was in the transfer position, and the rail by the wall was in the engaged position of resident #003's occupied bed. Review of the resident's clinical record and confirmation from registered staff #116, identified that the resident was able to move in the bed. Registered staff #116 also confirmed that the resident had not been assessed for the use of bed rails. (536)

D) According to their clinical record, resident #022 had a fall on an identified date, was hospitalized and received treatment for their injury. Upon return from hospital, the resident's plan of care was updated. This care included receiving identified medications, and extensive assistance from one staff for bed mobility and transfers. As well, they were at risk for falls. On an identified date, they were notably confused and began getting up from their bed unassisted. Review of clinical records indicated that the resident had not been assessed for the use of bed rails.

During interview, registered staff #100 and PSW staff #101 stated that the resident's family wanted the resident to have assist rails in the engaged position on either side of the bed. They also stated that the resident was restless and attempted to get out of their bed frequently after returning from hospital. The resident was noted in progress notes as trying to climb out of their bed. The progress notes on an identified date, stated the resident was found trying to get out of bed. On another identified date, the progress notes once again that the resident was found trying to get out of bed. Review of resident #022's health record revealed, that they had not been assessed in relation to the use of bed rail. Registered staff #100 confirmed that the resident had not been assessed when bed rails were in use to minimize risk to the resident. (526)

During interview, the DOC confirmed that residents #002, #003, #005, and #022 should have been assessed when bed rails were in use 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".***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's resident-staff communication and response system clearly indicated when activated where the signal was coming from.

The home's resident-staff communication and response system consisted of call bell stations that triggered the system, a light that turned on a panel above the door of the room where the system was triggered, a sound at the home area nursing station, a sign in the hallway informing staff where the signal was coming from and personal support workers (PSW) staff's use of paging devices that vibrated and/or sounded when the system was triggered.

During tour of an identified home area on an identified date, Inspector #526 observed that the light above the door to the spa room did not light up when the call bell was

triggered inside the spa room. In addition, staff did not respond to the system being triggered, and a sound could not be heard when standing along the far side of the home area in the hall, or in resident rooms located in this hallway. During interview, registered staff #100 and the home's Maintenance Supervisor confirmed that the light was not functioning, and that a sound could not be heard throughout the home area. Registered staff #110, the Maintenance Supervisor, and the Director of Care (DOC) stated that the staff would become aware that the system was triggered when the pagers they should carry vibrated or sounded.

During interview, PSW #101 confirmed that they saw that the system had been triggered in the spa room when standing close to the nursing station, where they heard an alarm and saw the room number/name illuminated on an electric sign that was located near the nursing station. PSW #101, #102, and #108 were PSWs who were working on the identified home area that day and stated that they were not carrying their pagers at that time. PSW #102 stated that they normally worked on another home area, and therefore didn't have a pager while working on the specified home area. PSW's #101 and #108 stated that their pagers were low on battery and were being fixed. Registered staff #100 stated that they had sent a pager to be fixed, and it had not been returned for an extended period of time that was greater than two weeks, but they couldn't remember exactly how long. The Administrator provided the home's policy titled "How to Use Pagers for the Call Bell System" last updated: March 2, 2012, that directed staff to "sign out the pager in the 'pager sign out book' and "put a battery in the pager from the 'charged battery' bin". The Administrator and DOC stated that the policy was out of date and was not being followed.

The Maintenance Supervisor provided documentation that indicated that a monthly schedule was in place to ensure that call bell stations triggered the system, but did not include regular monitoring that all pagers in the home were functioning. During interview, the Maintenance Supervisor stated that the home did not have a remedial maintenance program for the pagers. They also stated that staff should bring their pagers to the front desk if they weren't working properly, or needed a new battery. The Maintenance Supervisor stated that they were not sure if there were extra pagers if needed.

The Administrator, DOC and the Maintenance Supervisor confirmed, that the system's activated sound and signage at the nursing station could not be heard or seen throughout the identified home area, the light above the spa room was not functioning, and staff working on the identified home area were not carrying their pagers. They confirmed that, in light of these facts, that the home's resident-staff communication and

response system did not clearly indicate when activated where the signal was coming from. [s. 17. (1) (f)]

***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 and ensuring that the home's resident-staff communication and response system clearly indicated when activated where the signal was coming from, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee shall ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A review of the admission Minimum Data Set (MDS) assessment dated on an identified date, for resident #021 was coded as the resident being fully continent. The MDS assessment for resident #021 dated on another specified date, identified that the resident had worsening incontinence. A review of the MDS assessment dated an identified date, for resident #018 was coded that the resident was usually continent. The MDS assessment for resident #018 dated on another identified date, identified that the resident had worsening incontinence.

The home's policy "Continence Management Program" Policy number: RESI-10-04-01", last revision: November 2013 stated: "An assessment is completed: upon admission; with any deterioration in continence level; at required jurisdictional frequency if different from above and with any change in condition that may affect bladder and bowel continence". The RAI/MDS Coordinator confirmed that a continence assessment was not completed, when the worsening incontinence was identified for resident #018 and #021. [s. 51. (2) (a)]

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all staff in the home (s. 76. (1)) who received orientation training (s. 76. (2)), received retraining (s. 76. (4)) in the following areas, and that the retraining was at annual intervals in accordance with subsection 219. (1) of the regulations.

The Inspector attempted to review 2015 dietary staff training records that included: the Residents' Bill of Rights; the long-term care home's mission statement; the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26.; the long-term care home's policy to minimize the restraining of residents; fire prevention and safety; emergency and evacuation procedures; infection prevention and control; all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities; and any other areas provided for in the regulations.

During interview, the Food Service Supervisor (FSS) reported that they had started their employment on an identified date at the home, and they could not locate the records. They stated they had spoken with the former FSS who stated that they had not completed the 2015 mandatory training for dietary staff in the home. During interview, the Dietary Supervisor who was responsible for training dietary staff in the home stated, they were not aware that the 2015 mandatory training was their responsibility and confirmed that they had not completed the mandatory training for dietary staff. During interview, the Administrator stated in light of the above findings not all staff in the home had received mandatory training in 2015, in accordance with s. 76(4) according to legislative requirements. [s. 76. (4)]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Resident #023 was at risk for falls. According to their clinical record they had a fall on an identified date, sustained an injury and were sent to hospital for treatment. A review of the resident's plan of care and interview with PSW staff #120 indicated that prior to the injury, the resident was transferred with the assistance of one staff, and was ambulatory with one staff and the use of a walker.
During interview, PSW staff #120 confirmed that, upon return from hospital, resident #023 had a decrease in their independence and they required the use of a mechanical lift for transfers, and the use of a wheelchair for mobility.

Review of the Critical Incident System (CIS) indicated that the home had not informed the Director, when resident #023 had sustained an injury for which they were sent to hospital resulting in a significant change in condition according to subsection 107(3.1) of the regulations. During interview with the DOC, they confirmed that they had not informed the Director when resident #023 sustained an injury, and were sent to hospital which resulted in a significant change in condition. [s. 107. (3) 4.]

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**Issued on this 9th day of January, 2017**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | CATHIE ROBITAILLE (536), THERESA MCMILLAN (526) |
| **Inspection No. / No de l'inspection :** | 2016_553536_0021 |
| **Log No. / Registre no:** | 031882-16 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Dec 14, 2016 |
| **Licensee / Titulaire de permis :** | EXTENDICARE (CANADA) INC.<br>3000 STEELES AVENUE EAST, SUITE700,<br>MARKHAM, ON, L3R-9W2 |
| **LTC Home / Foyer de SLD :** | EXTENDICARE BRAMPTON<br>7891 Mclaughlin Road, BRAMPTON, ON, L6Y-5H8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Karen Ptacek |

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

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. 2007, c. 8, s. 6 (2).

**Order / Ordre :**

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. 2007, c. 8, s. 6 (2).

The Licensee shall implement a plan to ensure that registered staff provide clinically appropriate assessment to residents. The plan shall include, but not limited to:

1. A mechanism to ensure that clinical assessments completed by registered staff take into account all contributing factors including subtle yet relevant changes in health status.
2. A schedule for ongoing monitoring of registering staff on these clinical assessments provided to residents.

**Grounds / Motifs :**

1. This order is made up on the application of the factors of severity (3), scope (1), and compliance history (2), in keeping with s. 6 (2) of the Act. This is in respect to the severity of actual harm/risk that the identified resident's experienced, the scope of this being isolated, and the licensee history of no non-compliance in regards to s. 6 (2) of the Act.

The licensee has failed to ensure that the care set out in the plan of care for resident #025 was based on an assessment of the resident and the needs and preferences of that resident.

A) A review was completed of resident #025's clinical record. Resident #025 was admitted into the home on an identified date. On an identified date, a care

conference was held for resident #025 with their family in attendance. An interview with the family as well as the care conference notes, specified that the family expressed concerns about the resident. Following the care conference the physician ordered a specified test. The progress notes by registered staff #113 stated, that resident #025 had identified symptoms. During interview with staff #113 they confirmed that they had not done any further assessment in regards to resident #025 symptoms.On another identified date, the progress notes by registered staff #112 stated that family was in to visit and resident was complaining of pain.

A review was completed of resident #025's records. The resident demonstrated a change in condition in the days leading up to their hospitalization. A review of the home's protocol "General Guideline for Management of Hyperglycemia in Type 2 Diabetes" stated: If blood glucose test exceeds a specified level, the nursing staff should follow steps: confirm test results; assess changes in resident's status and follow facility protocol/medical directive/treatment plan including pain and report other conditions to physician: infection; acute coronary symptoms; other symptoms; and monitoring-following sick day management protocol on blood glucose testing, dietary changes and when to contact physician. Registered staff #113 confirmed that the home had a protocol for management of high blood glucose levels however, they had not implemented the protocol on that date. The plan of care for resident #025 which the home refers to as the care plan stated: "monitor and report signs of hyperglycemia i.e. extreme thirst, frequent urination, abdominal pain, fatigue, blurred vision, dry/flushed skin, shallow rapid breathing immediately.

On an identified date, the progress notes by registered staff #113 stated that the resident started the shift alert and responsive. The progress note also stated that during the identified meal that the resident had some specified symptoms, and that the resident also had to be fed their meal. On an identified date and time one of the resident's family members came in to visit. At an identified time, staff #113 received a call from the substitute decision maker (SDM) once again voicing concerns about the resident's health. As per the progress notes, registered staff went to the resident's room and asked family if they would like to send resident to the hospital and they agreed. The licensee did note ensure that care set out in the plan of care is based on an assessment of resident #025 and the needs of the resident.

B) A review was completed of resident #003's clinical record. The resident's plan

of care which the home refers to as the care plan, specified that the resident had side rails to assist with bed mobility and transfers. According to resident #003's Resident Assessment Inventory Minimum Data Set (RAI MDS) assessment completed on an identified date, bed rails were noted to be in use. However, on the RAI MDS assessment dated on three other identified dates, no bed rails were coded. The RAI/MDS Coordinator confirmed that coding of the side rails had been missed on all those identified RAI MDS assessments.

(536)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 01, 2017

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

**Order / Ordre :**

The licensee shall complete the following:

1.Review and revise as needed, the home's "Bed Entrapment and Proper use of Bedrail Devices" number 08-10-01, last revised April, 2011.
2.Conduct resident needs assessment for the use of bedrails to determine whether bed rails are to be used and which bed rail system is most appropriate.
3.Conduct Bed Rail Risk Assessments for each resident who are using bed rails, to minimize the risk of entrapment.
4.Take steps to minimize the risk of entrapment when bed rails are used, including when the resident uses an air mattress.
5.Evaluate the effectiveness of the home's Bed Entrapment and Proper Use of Bed Rail Devices policy.
6.Train all direct care staff in the home regarding the home's Bed Entrapment and Proper Use of Bed Rail Devices Policy.

**Grounds / Motifs :**

1. This order is made up on the application of the factors of severity (2), scope (3), and compliance history (4), in keeping with r. 15(1)(a) of the Regulation. This is in respect to the severity of potential or actual harm, the scope of this being widespread incidents, and the licensee history of non-compliance with a (VPC) in November 2014, during the Resident Quality Inspection for r. 15 (1) (a).

The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident. The "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings"(2003) had defined prevailing practices for the use of bed rails in long term care homes since 2010. The Guidelines state the following in relation to Individualized Patient Assessment when bed rails are in use for a resident: "Any decision regarding bed rail use or removal from use should be made within the framework of an individual patient assessment. If a bed rail has been determined to be necessary, steps should be taken to reduce the known risks associated with its use. The individual patient assessment includes medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); and risk of falling.

A) During observations on an identified date, bed rails were observed at the head of the bed in the raised position of resident #002's occupied bed while an air mattress was inflated with no additional devices installed to prevent entrapment. According to resident #002's Resident Assessment Inventory Minimum Data Set (RAI MDS) assessment completed on an identified date, bed rails were noted to be in use. Registered staff #105 and personal support worker (PSW) staff #103 confirmed that the resident could move themselves in the bed. A review of the resident's clinical record and confirmation from staff #105, indicated that the resident had not been assessed for the use of bed rails. (526)

During interview, the home's Maintenance Supervisor stated that they did not include beds with air mattresses in their annual bed entrapment audit, and that resident #005's bed was not assessed since it had an air mattress in place. The home's "Bed Entrapment Worksheet", confirmed that beds with air mattress's were not assessed. Registered staff #105 and PSW staff #013 confirmed that the resident was at risk for bed entrapment if their mattress became deflated, since the resident was able to move within the bed and any potential zones of entrapment had not been assessed or steps taken to prevent resident entrapment.

B) During observations on an identified date, resident #005 was observed in bed with two half bed rails in the engaged position. According to their RAI MDS assessment completed on an identified date, bed rails were noted to be in use. Registered staff #100 stated that the resident was able to move in the bed. Upon their return from hospital, the resident was not able to get out of bed and was unable to assist with bed mobility. Between return from hospital and this inspection, their transfer and bed mobility had improved, and the resident was ambulating to their wheelchair and was assisting with turning and repositioning while in bed. In addition, according to PSW staff #100, the resident's SDM had asked for the resident's assist rails to be in the engaged position rather than the assist position.

A review of the resident's clinical record indicated that they were last assessed for the use of bed rails on an identified. They had not been assessed since their condition changed upon return from hospital, or since a change in the use of bed rails from the assist position to the engaged position. (526)

C) During observations on an identified date, bed rail where observed on resident #003's bed. One rail was in the transfer position, and the rail by the wall was in the engaged position of resident #003's occupied bed. Review of the resident's clinical record and confirmation from registered staff #116, identified that the resident was able to move in the bed. Registered staff #116 also confirmed that the resident had not been assessed for the use of bed rails. (536)

D) According to their clinical record, resident #022 had a fall on an identified date, was hospitalized and received treatment for their injury. Upon return from hospital, the resident's plan of care was updated. This care included receiving identified medications, and extensive assistance from one staff for bed mobility and transfers. As well, they were at risk for falls. On an identified date, they were notably confused and began getting up from their bed unassisted. Review of clinical records indicated that the resident had not been assessed for the use of bed rails.

During interview, registered staff #100 and PSW staff #101 stated that the resident's family wanted the resident to have assist rails in the engaged position on either side of the bed. They also stated that the resident was restless and attempted to get out of their bed frequently after returning from hospital. The resident was noted in progress notes as trying to climb out of their bed. The progress notes on an identified date, stated the resident was found trying to get

out of bed. On another identified date, the progress notes once again that the resident was found trying to get out of bed. Review of resident #022's health record revealed, that they had not been assessed in relation to the use of bed rail. Registered staff #100 confirmed that the resident had not been assessed when bed rails were in use to minimize risk to the resident. (526)

During interview, the DOC confirmed that residents #002, #003, #005, and #022 should have been assessed when bed rails were in use in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)] (526)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 15, 2017

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 14th day of December, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Cathie Robitaille

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office