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 sions 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 |
|---|---|---|---|
| Jun 2, 2017 | 2017_560632_0007 | 006302-17 | Resident Quality Inspection |

## Licensee/Titulaire de permis

THE CORPORATION OF HALDIMAND COUNTY
45 Munsee Street Box 400 Cayuga ON N0A 1E0

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

GRANDVIEW LODGE / DUNNVILLE
657 LOCK STREET WEST DUNNVILLE ON N1A 1V9

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

YULIYA FEDOTOVA (632), BERNADETTE SUSNIK (120), CATHIE ROBITAILLE (536), KELLY CHUCKRY (611)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): April 10, 11, 12, 13, 18, 19, 20, 21, 2017.**

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

**Critical Incident System Report:**
**030348-16-related to: Prevention of Abuse and Neglect**
**035096-16-related to: Continence Care and Bowel Management**

**Inquiries:**
**035003-16-related to: Accommodation Services**

**Follow Ups:**
**035185-16-related to: Bed Rails**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Program Supervisor/Staff Development, Resident Assessment Instrument (RAI) Co-ordinator, Registered Dietitian (RD), the Food Service Supervisor, the Quality Assurance Nurse, Registered Practical Nurses (RPNs), Registered Nurses (RNs), dietary staff, Personal Support Workers (PSWs), housekeepers, residents, and family members.**

**During the course of the inspection, the inspector(s) conducted a tour of the home, including resident rooms and common areas, reviewed infection prevention and control, housekeeping, maintenance, reviewed documentation related to bed rails and relevant clinical records, conducted interviews, reviewed relevant policies, procedures, and practices within the home, reviewed meeting minutes, investigation notes, staff files, observed the provision of care, medication administration, and meal service.**

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

**Admission and Discharge**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**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.**
- **8 WN(s)**
- **2 VPC(s)**
- **1 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 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 residents were assessed where bed rails were used in accordance with prevailing practices to minimize risk to the resident.

The prevailing practice identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada) was identified in a notice issued to the Long-Term Care Home Administrators from the Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch in 2012 and provided the necessary guidance in establishing a clinical assessment where bed rails were used.

An inspection (2016-189120-0072) was previously conducted on November 14, 2016, and non-compliance identified related to resident bed safety clinical assessments. A compliance order with multiple conditions was issued on December 8, 2016 for a due date of March 31, 2017. The order included requirements to amend the home's existing forms to include; (1) questions related to a sleep assessment of the resident prior to the application of any bed rails, (2) alternatives that were trialled prior to the application of one or more bed rails and to document whether the alternatives were effective, (3) to 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, and (4) to provide families, residents and staff with specific written information or education related to bed safety. The requirements were confirmed to be outstanding during this inspection for requirements 2 to 4.

For this inspection, six residents were randomly selected for review, all of whom were observed to either have one or more bed rails in use or had care plans indicating that they required one or more bed rails as a Personal Assistance Services Device (PASD).

According to the Director of Nursing (DON), the assessment process and forms were amended as required and residents all received a clinical bed safety assessment by an interdisciplinary team consisting of registered nurses and personal support workers. Their conclusions were documented on an amended form titled "Bed Safety Assessment" (BSA). The assessment process included multiple forms with various components, beginning with a questionnaire for residents upon admission, accompanied by questions for the assessor to complete after observing the resident in bed without the use of bed rails for one night. A summary was to be completed, including whether any interventions were applied, such as a fall mat, bed alarm or bed in the lowest position. If the resident did not require one or more bed rails, the assessment was concluded. If they did, another form was to be completed with additional questions for nights two, three and four with bed rails applied. A final outcome component was to be completed identifying how many bed rails were to be used, the type of rail used, the purpose of their use, a time frame for their use and whether any risk factors were identified during the observation period in using them. The questions and processes were determined to comply with the order with the exception of the summary component related to what alternatives were trialled, and whether successful or not and, the updates to the residents’ written plan of care where changes were made. The BSA included what “interventions” (action taken to improve a situation) were used on the first night and listed three options, mostly related to falls prevention such as a fall mat, bed alarm or bed in the lowest position. There was no additional direction in the home’s policy “Bedrail Entrapment Policy (35-2)” or on the forms directing staff to try “alternatives” (a replacement), to a hard bed rail before choosing the hard bed rail option. Alternatives would include but are not limited to a soft rail (bolster), toileting schedule, mattress pull or grip handles, wall bar, reaching pole, increased monitoring, pain management, perimeter reminders (body pillow, raised or lipped mattress) and anticipating reasons why a resident would need to get out of bed unassisted and meeting the assessed need.

According to records provided, the number of residents requiring the use of one or more bed rails decreased by over 50% from the previous inspection. The number of residents who were determined to benefit from the use of one or more bed rails was reduced to a total of 20 residents. The records provided indicated which residents did not use bed rails. However, during the inspection, on of the home's area, sixteen residents with bed rails applied were observed, in contradiction to the report that indicated there were only

eight. The beds were noted to have either a quarter bed rail elevated, a rotating assist rail in the transfer position or a fixed assist rail.

According to the DOC, the bed rails were scheduled to be removed from specific beds in all four home areas and that maintenance staff were given a list of the beds in early April, 2017. Their plan was to systematically go through each home area and re-evaluate the beds for entrapment zones and at the same time, the RN would update the resident's written plan of care. Only one home area had been completed by the time of inspection.

1. Resident #901 was admitted to the home in November, 2016, and a registered nurse (RN) determined that bed rails would be used for bed mobility at that time. A risk over benefit analysis for bed rail use was not completed at that time. Upon re-assessment, using the amended BSA form on an identified date in March, 2017, the RN determined that the resident did not need the bed rails for bed mobility. However, at the time of inspection, the resident was observed sleeping in bed with both quarter length bed rails elevated or applied. The resident's assessment did not include whether they were evaluated for risk of injury, strangulation or entrapment related to their bed system with bed rails applied. The resident's written plan of care had not been updated to include the latest assessment result. The resident's bed rails were scheduled to be removed and their plan of care updated.

2. Resident #902 was admitted to the home in 2011 and according to a written plan of care dated on an identified date in December, 2015, the resident would use "one partial" bed rail to transfer, reposition and turn in bed while engaged and that the bed rail was disengaged when not in use (no side was indicated). The terminology was confusing and the terms were clarified with an RN. An engaged bed rail meant that it was in the "guard" position (according to manufacturer's instructions) and disengaged meant that the bed rail was in the "transfer" position. The term "partial" was clarified to be a rotating assist rail, with a 180 degree rotation capability. With this type of bed rail, whether in guard or in transfer position, the bed rail was always in "use" or applied. The bed rail was capable of being rotated backwards and below the level of the mattress. However if the bed was too low to the floor, the bed rail could not be rotated below the level of the mattress. The type of bed rail would therefore not be indicated for residents who had any risk factors for bed injury related to bed rails. The resident's bed was observed at the time of inspection to have the right side bed rail in the transfer position. The resident's BSA form, when acquired by the DOC, was missing a page for each night of the sleep observation (with bed rails applied) and was therefore missing the outcome of the sleep observations, staff signature and date. The BSA assessment for the first night, which required no bed rail

application, was completed in April, 2017. It included, under the "interventions" section, that the resident had the bed in the lowest position with mat on the floor. With all of the above information, the resident's bed was not without bed rails during the first night. A bed in the lowest position cannot have bed rails rotated below the level of the mattress. The resident in this case had bed rails applied throughout the night. The RN did not include whether any alternatives were trialled before the hard bed rails were applied, but included interventions for falls prevention.

3. Resident #104 was admitted to the home in October, 2016, and no information was noted in the resident's written plan of care at the time regarding the use of bed rails. A bed rail assessment was completed on an identified date in November, 2016, indicating that no bed rails were necessary. When the resident was re-assessed using the amended BSA form on an identified date in April, 2017, the RN determined that the bed rails were a safe device for the resident, and that the resident was able to self-transfer and reposition while in bed using the bed rails. At the time of inspection, the resident's bed was observed to have both quarter length bed rails elevated. The RN documented that no interventions were needed, did not indicate whether any alternatives were trialled prior to applying the bed rails and did not identify how many bed rails would be used, on which side, when and the type of bed rail used. The resident's written plan of care was not updated to include the latest assessment result.

4. Resident #905 was admitted to the home in 2007 and according to their written plan of care, an RN identified that bed rails would be used as a PASD as of an identified date in December 2015. Upon re-assessment using the amended BSA form on an identified date in March, 2017, the RN determined that the resident did not require bed rails because they got out of bed independently and could reposition themselves without the aid of a bed rail. The resident's bed was observed on an identified date in April, 2017, and the right side quarter length bed rail was elevated. The resident reported that they were able to apply the bed rails themselves and used both bed rails for repositioning while in bed. The resident's assessment did not include whether they were evaluated for risk of injury, strangulation or entrapment related to their bed system with bed rails applied. The resident's written plan of care was not updated to include the latest assessment result. The resident's bed rails were scheduled to be removed and their plan of care updated. Discussion was held with the DOC regarding the resident's self-reported need for the bed rails and a need to confirm whether they were a safe device for the resident.

5. Resident #906 was admitted to the home in November, 2016, and according to their

written plan of care dated November, 2016, an RN identified that both "partial" side rails would be engaged to assist the resident to turn. Upon re-assessment using the amended BSA form on an identified date in April, 2017, the RN determined that the resident continued to require the bed rails, but did not indicate why, when, how many bed rails would be used and on what side. The resident's bed was observed on an identified date in April, 2017, with both quarter bed rails elevated. The BSA form did not include what alternatives, if any were trialled, and the form was blank for a number of questions related to the resident's ability to reposition themselves and if they had a physical condition affecting their safe use of the bed rails.

The DOC presented a copy of a pamphlet that included some bed safety information, but did not include the details as listed in the order. The information that was to be provided to staff, families and residents were to include information from the prevailing practices and legislative reference for bed safety in Ontario and relevant facts and myths associated with bed rail use.

The licensee therefore did not ensure that residents were fully assessed where bed rails were used in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

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

A. Resident #099 was admitted to the long term care home on an identified date in September, 2016. An admission Minimum Data Set (MDS) assessment was completed at that time, and indicated that this resident required limited assistance and one personal physical assistance for dressing. The written plan of care for resident #099 indicated under the focus of dressing that this resident required one staff limited assistance.

Quarterly MDS assessments were completed on identified dates in December, 2016, and in March, 2017 that indicated that this resident required extensive assistance and one person physical assistance for dressing. The written plan of care for resident #099 indicated under the focus for dressing that this resident required one staff limited assistance.

In an interview conducted with staff #357 acknowledged that resident #099 required extensive assistance with one staff member for all aspects of dressing, A subsequent interview conducted with the RAI Co-ordinator acknowledged that the plan of care for resident #099 was not based on the assessment for the resident and the resident's needs. (611)

B. The Minimum Data Set (MDS) admission assessment dated on identified date in October, 2016, for resident #104 stated that they were continent of both bowel and

bladder when they were admitted. The most recent Minimum Data Set (MDS) assessment dated on an identified date in January, 2017, revealed that the resident's continence status for bowel had changed from continent to usually continent, and the resident's bladder continence status had also changed from usually continent to occasionally incontinent. The written plan of care for resident #104 indicated under the focus of continence that the resident was continent of both bowel and bladder. The Resident Assessment Instrument (RAI) Co-Ordinator acknowledged that the plan of care which the home refers to as the care plan should have been updated to reflect the change in resident #104's continence status. (536)

C. A review of a CIS submitted by the home and progress notes indicated that on an identified date in December, 2016, PSW #373 did not assist resident #079 with their toileting procedures. On an identified date in April, 2017, the resident indicated that they require extensive assistance since their last fall on an identified date in November, 2016, to be provided by one staff member with their toileting needs. On an identified date in April, 2017, interview with staff members #358 and #329 indicated that the resident required extensive assistance with one person for their toileting needs. Review of MDS assessment records (completed on an identified date in January, 2017) contained information on providing extensive assistance to the resident with two+ persons physical assist, however the resident's plan of care contained the information that the resident required guidance with transfers on/off the toilet or commode with one staff assistance to use toilet. Review of the most current plan of care related to the resident's toilet use also did not contain the information based on the most recent MDS assessment (locked date on an identified date in April, 2017) based on the need of extensive assistance with one person for toilet use. On on an identified date in April, 2017, RAI-Co-ordinator acknowledged that the care set out in the plan of care for resident #079 was not based on an assessment of the resident's needs. (632) [s. 6. (2)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any time when, the resident`s care needs change or care set out in the plan was no longer necessary.

On identified dates in April 2017, during lunch observation in resident home area, resident #021 with swallowing difficulties was sitting in an upright position, while their wheel chair was positioned in a specific manner while total assistance was provided with eating. An interview with staff members #304, #340 and #384, identified that the resident's chair was in a specific manner to keep them in upright position. On an identified date in April, 2017, the resident was observed sitting in upright position while

their wheel chair back was in upright position. An interview with staff member #365, identified that the resident's chair was not positioned in a specific manner to keep them in upright position based on resident`s current condition. Review of the most current plan of care did not contain information related to the use of positioning in a specific manner in wheelchair for the resident during eating. On an identified date in April, 2017, the Director of Nursing, acknowledged that the most current care plan did not reflect the resident's requirements in regards to positioning at mealtimes. The staff did not ensure that plan of care for the resident was reviewed and revised at any time when, the resident`s care needs change. [s. 6. (10) (b)]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance**

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

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

A review of a CIS submitted by the home and progress notes indicated that on an identified date in October, 2016, abuse by staff member to resident #128 occurred in one of the home's areas. Review of "Resident Abuse - Investigating and Reporting" Policy No.: A -1.2 (reviewed September 2016) stated that "the home's Administrator or designate were responsible to immediately call the MOHLTC at 1-800-268-6060 to report" suspected or witnessed resident's abuse. Review of critical incident report indicated that CIS was submitted on an identified date in October, 2016, which was confirmed by the Administrator on an identified date in April, 2017. The licensee did not ensured that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

This non-compliance was identified during CIS inspection log # 030348-16. [s. 20. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information**

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

**s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a copy of the Long-Term Care Service Accountability Agreement (LSAA) was posted in a conspicuous and easily accessible location.

On an identified date in April, 2017, during tour of the home the inspector was unable to locate a copy of the LSAA. The Director of Nursing confirmed that the LSAA was not posted in a conspicuous and easily accessible location. [s. 79. (1)]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,**
**(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;**
**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;**
**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**
**(d) that the changes and improvements under clause (b) are promptly implemented; and**
**(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

A review of a CIS submitted by the home and progress notes indicated that on an identified date in October, 2016, abuse by staff member to the resident #128 occurred in one of the home's area. Review of investigation notes and training records indicated that no evaluation was completed in 2016 to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences, which was confirmed by the Administrator on an identified date in April, 2017. [s. 99. (b)]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation**

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

**s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

On an identified date in April, 2017, the Quality Assurance Nurse provided the Inspector with their Institute for Safe Medication Practices (ISMP) stating this was their 2016 annual evaluation. The home was unable to provide an annual evaluation for medication management as per the legislative requirements. [s. 116. (1)]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs obtained for use in the home except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three-month supply was kept in the home at any time.

On an identified date in April, 2017, the government stock drug supply was inspected. The Inspector noted that there were 13 boxes of Dulcolax suppositories containing 100 suppositories per box; 20 bottles of Almagel 350 millilitres(mls) per bottle; 26 bottles of Sofulax containing100 capsules per bottle and 21 boxes of Gravol suppositories, which included 10 suppositories per box. Registered staff #305, and the Director of Nursing acknowledged that the drugs mentioned above were more than a three month supply. [s. 124.]

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information**

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

**s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:**
**1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).**
**2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).**
**3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).**
**4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).**
**5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the most recent audited reconciliation report was posted and communicated.

On an identified date in April, 2017, during tour of the home the inspector was unable to locate the most recent audited reconciliation report. The Director of Nursing confirmed that the most recent audited reconciliation was not posted in a conspicuous and easily accessible location. [s. 225. (1) 3.]

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**

**Issued on this 7th day of June, 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 sions de longue durée**

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | YULIYA FEDOTOVA (632), BERNADETTE SUSNIK (120), CATHIE ROBITAILLE (536), KELLY CHUCKRY (611) |
| **Inspection No. / No de l'inspection :** | 2017_560632_0007 |
| **Log No. / Registre no:** | 006302-17 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Jun 2, 2017 |
| **Licensee / Titulaire de permis :** | THE CORPORATION OF HALDIMAND COUNTY<br>45 Munsee Street, Box 400, Cayuga, ON, N0A-1E0 |
| **LTC Home / Foyer de SLD :** | GRANDVIEW LODGE / DUNNVILLE<br>657 LOCK STREET WEST, DUNNVILLE, ON, N1A-1V9 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Joanne Jackson |

To THE CORPORATION OF HALDIMAND COUNTY, 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)

**Linked to Existing Order / Lien vers ordre existant:** 2016_539120_0072, 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 shall complete the following:

1. Amend the "Bed Safety Assessment" form to include the alternatives that were trialled prior to the application of one or more bed rails and document how long the alternative was trialled and whether the alternative was effective or not.

2. Bed rail use by residents that were assessed as not requiring them, shall be monitored to ensure that until such time they are removed, as per the decision of the licensee, that those bed rails are not applied.

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 the type of bed rail(s) used by the resident, how many, on what side of the bed, when they are to be applied and why.

4. Develop an education and information package for staff, families and residents, identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails.

**Grounds / Motifs :**

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

The prevailing practice identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada) was identified in a notice issued to the Long-Term Care Home Administrators from the Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch in 2012 and provided the necessary guidance in establishing a clinical assessment where bed rails were used.

An inspection (2016-189120-0072) was previously conducted on November 14, 2016, and non-compliance identified related to resident bed safety clinical assessments. A compliance order with multiple conditions was issued on

December 8, 2016 for a due date of March 31, 2017. The order included requirements to amend the home's existing forms to include; (1) questions related to a sleep assessment of the resident prior to the application of any bed rails, (2) alternatives that were trialled prior to the application of one or more bed rails and to document whether the alternatives were effective, (3) to 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, and (4) to provide families, residents and staff with specific written information or education related to bed safety. The requirements were confirmed to be outstanding during this inspection for requirements 2 to 4.

For this inspection, six residents were randomly selected for review, all of whom were observed to either have one or more bed rails in use or had care plans indicating that they required one or more bed rails as a Personal Assistance Services Device (PASD).

According to the Director of Care (DOC), the assessment process and forms were amended as required and residents all received a clinical bed safety assessment by an interdisciplinary team consisting of registered nurses and personal support workers. Their conclusions were documented on an amended form titled "Bed Safety Assessment" (BSA). The assessment process included multiple forms with various components, beginning with a questionnaire for residents upon admission, accompanied by questions for the assessor to complete after observing the resident in bed without the use of bed rails for one night. A summary was to be completed, including whether any interventions were applied, such as a fall mat, bed alarm or bed in the lowest position. If the resident did not require one or more bed rails, the assessment was concluded. If they did, another form was to be completed with additional questions for nights two, three and four with bed rails applied. A final outcome component was to be completed identifying how many bed rails were to be used, the type of rail used, the purpose of their use, a time frame for their use and whether any risk factors were identified during the observation period in using them. The questions and processes were determined to comply with the order with the exception of the summary component related to what alternatives were trialled, and whether successful or not and, the updates to the residents' written plan of care where changes were made. The BSA included what "interventions" (action taken to improve a situation) were used on the first night and listed three options, mostly related to falls prevention such as a fall mat, bed alarm or bed in the lowest position. There was no additional direction in the home's policy "Bedrail

Entrapment Policy (35-2)" or on the forms directing staff to try "alternatives" (a replacement), to a hard bed rail before choosing the hard bed rail option. Alternatives would include but are not limited to a soft rail (bolster), toileting schedule, mattress pull or grip handles, wall bar, reaching pole, increased monitoring, pain management, perimeter reminders (body pillow, raised or lipped mattress) and anticipating reasons why a resident would need to get out of bed unassisted and meeting the assessed need.

According to records provided, the number of residents requiring the use of one or more bed rails decreased by over 50% from the previous inspection. The number of residents who were determined to benefit from the use of one or more bed rails was reduced to a total of 20 residents. The records provided indicated which residents did not use bed rails. However, during the inspection, in one of the home's areas, sixteen residents with bed rails applied were observed, in contradiction to the report that indicated there were only eight. The beds were noted to have either a quarter bed rail elevated, a rotating assist rail in the transfer position or a fixed assist rail.

According to the DOC, the bed rails were scheduled to be removed from specific beds in all four home areas and that maintenance staff were given a list of the beds in early April, 2017. Their plan was to systematically go through each home area and re-evaluate the beds for entrapment zones and at the same time, the RN would update the resident's written plan of care. Only one home area had been completed by the time of inspection.

1. Resident #901 was admitted to the home in November, 2016, and a registered nurse (RN) determined that bed rails would be used for bed mobility at that time. A risk over benefit analysis for bed rail use was not completed at that time. Upon re-assessment, using the amended BSA form on an identified date in March, 2017, the RN determined that the resident did not need the bed rails for bed mobility. However, at the time of inspection, the resident was observed sleeping in bed with both quarter length bed rails elevated or applied. The resident's assessment did not include whether they were evaluated for risk of injury, strangulation or entrapment related to their bed system with bed rails applied. The resident's written plan of care had not been updated to include the latest assessment result. The resident's bed rails were scheduled to be removed and their plan of care updated.

2. Resident #902 was admitted to the home in 2011 and according to a written

plan of care dated on an identified date in December, 2015, the resident would use "one partial" bed rail to transfer, reposition and turn in bed while engaged and that the bed rail was disengaged when not in use (no side was indicated). The terminology was confusing and the terms were clarified with an RN. An engaged bed rail meant that it was in the "guard" position (according to manufacturer's instructions) and disengaged meant that the bed rail was in the "transfer" position. The term "partial" was clarified to be a rotating assist rail, with a 180 degree rotation capability. With this type of bed rail, whether in guard or in transfer position, the bed rail was always in "use" or applied. The bed rail was capable of being rotated backwards and below the level of the mattress. However if the bed was too low to the floor, the bed rail could not be rotated below the level of the mattress. The type of bed rail would therefore not be indicated for residents who had any risk factors for bed injury related to bed rails. The resident's bed was observed at the time of inspection to have the right side bed rail in the transfer position. The resident's BSA form, when acquired by the DOC, was missing a page for each night of the sleep observation (with bed rails applied) and was therefore missing the outcome of the sleep observations, staff signature and date. The BSA assessment for the first night, which required no bed rail application, was completed on an identified date in April, 2017. It included, under the "interventions" section, that the resident had the bed in the lowest position with mat on the floor. With all of the above information, the resident's bed was not without bed rails during the first night. A bed in the lowest position cannot have bed rails rotated below the level of the mattress. The resident in this case had bed rails applied throughout the night. The RN did not include whether any alternatives were trialled before the hard bed rails were applied, but included interventions for falls prevention.

3. Resident #104 was admitted to the home in October, 2016, and no information was noted in the resident's written plan of care at the time regarding the use of bed rails. A bed rail assessment was completed on an identified date in November, 2016, indicating that no bed rails were necessary. When the resident was re-assessed using the amended BSA form on an identified date in April, 2017, the RN determined that the bed rails were a safe device for the resident, and that the resident was able to self-transfer and reposition while in bed using the bed rails. At the time of inspection, the resident's bed was observed to have both quarter length bed rails elevated. The RN documented that no interventions were needed, did not indicate whether any alternatives were trialled prior to applying the bed rails and did not identify how many bed rails would be used, on which side, when and the type of bed rail used. The

resident's written plan of care was not updated to include the latest assessment result.

4. Resident #905 was admitted to the home in 2007 and according to their written plan of care, an RN identified that bed rails would be used as a PASD as of an identified date in December, 2015. Upon re-assessment using the amended BSA form on an identified date in March, 2017, the RN determined that the resident did not require bed rails because they got out of bed independently and could reposition themselves without the aid of a bed rail. The resident's bed was observed on an identified date in April, 2017, and the right side quarter length bed rail was elevated. The resident reported that they were able to apply the bed rails themselves and used both bed rails for repositioning while in bed. The resident's assessment did not include whether they were evaluated for risk of injury, strangulation or entrapment related to their bed system with bed rails applied. The resident's written plan of care was not updated to include the latest assessment result. The resident's bed rails were scheduled to be removed and their plan of care updated. Discussion was held with the DOC regarding the resident's self-reported need for the bed rails and a need to confirm whether they were a safe device for the resident.

5. Resident #906 was admitted to the home in November, 2016, and according to their written plan of care dated on an identified date in November, 2016, an RN identified that both "partial" side rails would be engaged to assist the resident to turn. Upon re-assessment using the amended BSA form on an identified date in April, 2017, the RN determined that the resident continued to require the bed rails, but did not indicate why, when, how many bed rails would be used and on what side. The resident's bed was observed on an identified date in April, 2017, with both quarter bed rails elevated. The BSA form did not include what alternatives, if any were trialled, and the form was blank for a number of questions related to the resident's ability to reposition themselves and if they had a physical condition affecting their safe use of the bed rails.

The DOC presented a copy of a pamphlet that included some bed safety information, but did not include the details as listed in the order. The information that was to be provided to staff, families and residents were to include information from the prevailing practices and legislative reference for bed safety in Ontario and relevant facts and myths associated with bed rail use.

The licensee therefore did not ensure that residents were fully assessed where

bed rails were used in accordance with prevailing practices to minimize risk to the resident.

This order is based upon three factors where there has been a finding of non-compliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to s. 15(1) of Ontario Regulation 79/10, the scope of the non-compliance is pattern, as more than one of the residents who used one or more bed rails was not assessed in accordance with prevailing practices, the severity of the non-compliance has the potential to cause harm to residents related to bed safety concerns and the history of non-compliance is on-going as an order was previously issued on December 8, 2016. (120)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 02, 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
TORONTO, 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
TORONTO, 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 2nd day of June, 2017**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Yuliya Fedotova

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