Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 13, 2018;	2017_593573_0026 (A1)	024538-17	Resident Quality Inspection

Licensee/Titulaire de permis

Arnprior Regional Health
350 John Street North ARNPRIOR ON K7S 2P6

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

The Grove, Arnprior and District Nursing Home
275 Ida Street North ARNPRIOR ON K7S 3M7

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

KATHLEEN SMID (161) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home's CEO Eric Hanna requested on March 13, 2018 a 2 week extension to the CO #001 O.Reg. 79/10 s. 15 related to bedrails to ensure that all of the required elements of the order are completed. The new compliance date is April 6, 2018. The extension has been granted.

Issued on this 13 day of March 2018 (A1)

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

Original report signed by the inspector.

Ontario

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

KATHLEEN SMID (161) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): October 30, 31, 2017, November 01, 02, 03, 06, 07, 08 and 09, 2017.

The following complaint Log #024598 -17 related to resident care and services was conducted concurrently during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the home's Chief Executive Office (CEO), Director of Care (DOC), Assistant Director of Care (ADOC), Activity Coordinator, Dietary Manager, Environmental Service Manager, Physiotherapist, Dietitian, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping/ Laundry Aides, Activity/ Recreation staff, Dietary Aides, Cooks, President of Residents' Council, President of Family Council, Family members and Residents.

During the course of the inspection, the inspector(s) toured residential and non-residential areas of the home, observed medication administration passes, recreation activities, exercise therapy classes, meal and snack services, reviewed residents health care records, the licensee's relevant policies and procedures, minutes for Residents' and Family Council. In addition, Inspectors observed the provision of care and services to the residents, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On August 21, 2012, a Memo was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the memo, it was written that this Health Canada Guidance Document is expected to be used "as a best practice document".

The Health Canada Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the Health Canada Guidance Document are identified as “useful resources” and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home

Care Settings" (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment for residents where bed rails are used. In this document, it was recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including, but not limited to, the resident's medical diagnosis, sleep habits, medications, ability to toilet self, existence of delirium, cognition, communication, mobility in and out of bed, risk of falls and potential safety risks posed by using any type of bed rail.

The clinical guidance document describes that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

In addition to providing guidance in establishing a clinical assessment where bed rails are used, the HC Guidance Document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools (the cone and cylinder tool) and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

On October 31 and November 01, 2017, Inspector #548 observed resident #031, #032 and #033's bed system with two ¼ bed rails that were raised at the head of the bed. Inspector #548 observed that there was approximately four to six inches gap between the end of the mattress and the headboard (Zone 7).

On November 02, 2017, Inspector #573 reviewed resident #031, #032 and #033's written plan of care in place, which identified the use of two ¼ bed rails for resident's bed mobility and safety. Further, upon review of resident's health care record, Inspector was unable to locate any assessment related to the use of bed rails for the residents.

On November 03, 2017, Inspector #573 spoke with the home's ADOC regarding above three resident assessments and their bed system evaluation related to the use of ¼ bed rails. The ADOC indicated that with the help of registered nursing staff all the residents were assessed (Bed Safety Assessment) related to the use of bed rails. The ADOC indicated that the home's DOC and the physiotherapist completed the bed entrapment assessment for all the resident bed systems with the bed rails. Further, the ADOC indicated that the bed safety assessment was not documented for all the residents.

On November 06, 2017, Inspector #573 reviewed resident #031, #032 and #033's completed bed safety assessments and found out that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective was not documented in the resident bed safety assessment.

During an interview on November 06, 2017, the home's DOC indicated that for all the resident's bed system with bed rails, a comprehensive resident bed safety assessment was not completed. The DOC indicated that for all the residents' bed system where the bed rails in use, the residents were assessed for the safety regarding the use of bed rails. She indicated that with the help of home's physiotherapist they completed the bed entrapment assessment by using a measuring tape. The DOC indicated to the Inspector that they did not use the cone and cylinder tool for the bed entrapment assessment as directed by the Health Canada Guidance Document. The DOC indicated that out of 60 residents only 12 bed safety assessment were documented. Further, she indicated to the Inspector #573 that the risk-benefit assessment was not documented in the residents health care record. [s. 15. (1) (a)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with fluids that are safe.

During the lunch meal service on October 30, 2017, it was observed by Inspector #548 that Cook #105 shook and stirred white powder (Thicken Up) unmeasured, into the beef and barley soup that was served to resident's #010, #028, #034 and #040.

On October 30, 2017, during an interview Cook #105 indicated to Inspector #548 that there are several residents that require their soup to be thickened to either a nectar or honey consistency. She indicated that there is a thickening guideline for different types of fluid consistencies and she visually judges the thickened consistency of the soup prior to it being provided to the residents.

It was also observed by Inspector #548 that there was a can of Thicken Up powder on the fluid cart in the dining room. During an interview the recreation assistant #130 indicated that fluids are thickened at the point of service. She indicated that she is aware of the thickening guidelines for the desired consistency and uses the cutlery teaspoon or a plastic cutlery spoon to measure the quantity of Thicken Up and adds that amount to the liquid. She indicated that she visually observes the thickened state of the liquid to be the correct consistency prior to it being provided to the resident. She indicated that a cutlery teaspoon measures 15 millilitres (mls).

Inspector #548 reviewed resident #010, #028, #034 and #040's care plan which identified that related to their diagnosis specified consistency thickened fluids are to be provided to the residents. The dietary roster available in the dining room for staff

indicated that resident's #010, #028 and #034 are to be provided with specified consistency thickened fluids.

On November 06, 2017, during a lunch meal observation it was observed that Cook #129 shook and stirred white powder (Thicken Up), unmeasured, into lentil soup that was served to resident #010, #028, #034 and #040.

On November 07, 2017, during an interview with the Dietary Manager, she indicated that the staff use the cutlery teaspoon to measure out the amount of Thicken Up that is added to these resident's fluids. In the presence of the Inspector #548, she measured one level teaspoon of Thicken Up to equal 5 mls.

The Thickening Guidelines from the home indicated for 'Nectar' consistency three teaspoons (tsp) for six ounce (oz) cup (180 mls) for juice and two tsp for four oz (125 mls) of liquids and two and half tsp for 5 oz bowl (150 mls) for soup. For 'Honey' consistency five teaspoons (tsp) for six ounce (oz) cup (180 mls) for juice and three tsp for four oz (125 mls) of liquids and four tsp for 5 oz bowl (150 mls) for soup.

The thickening agent currently used by the home is called 'Thicken Up'. The recommended guidelines on the container indicated that to achieve a desired consistency- 'Nectar' 15 mls of Thicken Up is to be added to 120 mls of fluid and for 'Honey' consistency 20 mls is to be added.

The home's has two sizes of cups that are used for liquids. In the presence of the Inspector #548 Cook #105 measured the juice and water cups to be 125 mls and the cup used for milk to measure 250mls. The Cook indicated that she thought the soup bowl held 6 ounces of volume (180 mls); the soup bowl measured 130 mls.

The licensee failed to ensure that residents #010, #028, #034 and, #040 are provided fluids that are safe. [s. 11. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents #010, #028, #034 and #040 are provided with the recommended thickened consistency of fluids, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #042 in accordance with the directions for use specified by their prescriber.

On an identified date, the Attending Physician of resident #042 prescribed two specified drugs that are to be administered daily to the resident. A month later on an identified date, RPN#112 reviewed resident #042's Physician's Orders and compared the medications prescribed with resident #042's Medication Administration Record (MAR) in place. RPN #112 observed that the prescriptions for both the specified drugs had not been transcribed onto the MAR in place.

On November 07, 2017, Inspector #161 reviewed resident #042's MAR for two specified months. It was noted that resident #042 was not administered 27 doses of two specified drugs that were to have been administered daily as of a specified month in 2017. [s. 131. (2)]

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 drugs are administered to resident #042 in accordance with the directions for use specified by their prescriber, to be implemented voluntarily.

WN #4: 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 resident-staff communication and response system is available in every area accessible by residents.

On October 30, 2017, Inspector #548 observed that the home's Chapel was not equipped with a resident-staff communication and response system (Call bell).

On October 30, 2017 and on November 02, 2017, it was observed by Inspector #548 that residents had congregated in the chapel for a religious service.

The home's Recreation Schedule for October and November 2017 was reviewed. Resident specific activities such as; religious services, music and book club are scheduled to be provided in the Chapel.

On November 06, 2017, during an interview with Inspector #548 the DOC indicated that the Chapel is a resident-designated area for social and scheduled activities. She also added that families and volunteers would accompany the resident in the Chapel. The DOC agreed that a call bell should be in place. [s. 17. (1) (e)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written procedure and protocol to report and locate residents' lost clothing and personal items as required by O. Reg 79/10, 89.1(a)(iv).

As per O.Reg. 79/10, s.30 (1) 1. "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

As per O.Reg. 79/10, s.89 (1), "As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that,(iv) there is a process to report and locate residents' lost clothing and personal items."

On October 31, 2017, during an interview, resident #039 stated to Inspector #548 regarding resident's clothes that went missing a week ago. Resident #039 indicated that the missing items were reported to the staff and the items are still missing.

On November 09, 2017, Inspector #573 spoke with Housekeeping/ Laundry Aide #127, who indicated that a week ago resident #039 reported to her and PSW staff members regarding the missing clothing items. Staff #127 indicated that she searched in the laundry and was not able to find the resident's missing clothing. Further, the staff indicated that she informed the registered nursing staff on the unit about the resident's missing clothing.

During an interview with PSW #122, who indicated to Inspector #573 that she was not aware of resident #039's missing clothing. When the inspector inquired about the home's process for reporting and locating residents lost clothing, PSW #122 indicated that the staff members will report to the registered nursing staff in the unit and will search the missing clothing in the resident's room. The PSW staff indicated that the registered nursing staff will report to the laundry department and the house keeping staff will search for the missing clothing in the laundry.

On November 09, 2017, Inspector #573 spoke with RPN #108 who indicated that she was not aware of the resident #039's missing clothing items. RPN #108 indicated that she was not reported by the PSW staff members nor the housekeeping/ laundry staff members about the resident's missing clothing items. Inspector #573 and RPN #108 reviewed the nursing 24 hours report and the communication binder and not able to find any information about the resident #039's missing clothing items.

Inspector #573 spoke with home's ADOC regarding the process for reporting and locating residents lost clothing. The ADOC indicated to the inspector that when registered nursing staff was informed about resident's missing clothing, the registered nursing staff will document the information in the nursing communication binder or in the 24 hours shift report for a follow up. The ADOC indicated that PSW

staff members will search for the resident's missing clothing item in the resident's room. She stated that the laundry department will be informed, so that the housekeeping staff will search in the laundry for the resident's missing clothing. Further, the home's ADOC indicated to Inspector #573 that the home does not have a written procedure and protocol to report and locate residents' missing or lost clothing. [s. 30. (1) 1.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply, including that all areas where drugs are stored shall be kept locked at all times, when not in use and that access to these areas shall be restricted to, persons who may dispense, prescribe or administer drugs in the home.

On October 31, 2017, Inspector #161 and the home's ADOC entered the locked clean supply room adjacent to the nursing station. Inspector #161 observed nutritional supplements in the refrigerator, and prescribed topical drugs in three open boxes located on a shelf. During discussion with Inspector #161, the ADOC indicated that a dietary aide unlocks the clean supply room door to stock the refrigerator daily with nutritional supplements.

On November 01, 2017, during discussion with Inspector #161, Dietary Aide #110 indicated that the dietary staff use their key to unlock the clean supply room adjacent to the nursing station to stock the refrigerator daily with nutritional supplements. The Dietary staff are not persons who may dispense, prescribe or administer drugs in the home and therefore they should not have access to a room where drugs are stored. [s. 130. 2.]

Issued on this 13 day of March 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : KATHLEEN SMID (161) - (A1)

Inspection No. / No de l'inspection : 2017_593573_0026 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 024538-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Mar 13, 2018;(A1)

Licensee / Titulaire de permis :
Arnprior Regional Health
350 John Street North, ARNPRIOR, ON, K7S-2P6

LTC Home / Foyer de SLD :
The Grove, Arnprior and District Nursing Home
275 Ida Street North, ARNPRIOR, ON, K7S-3M7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Eric Hanna

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Arnprior Regional Health, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

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 :

Ontario

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

The licensee is ordered to:

1. Ensure that an interdisciplinary team assess all residents in the home with one or more bed rails in use, in accordance with the 2003 FDA prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings". The resident's assessment shall include all factors, elements and conditions as outlined in the prevailing practices document.

2. Re-evaluate all resident's bed systems where bed rails are used in the home, in accordance with Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" to minimize risk to the resident.

3. Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment.

4. Ensure that the above assessments are documented including the names of team members participating in the assessment, the results of the assessment including the risk benefit assessment, and the recommendations. Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On August 21, 2012, a Memo was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the memo, it was written that this Health Canada Guidance Document is expected to be used "as a best practice document".

The Health Canada Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the Health Canada Guidance Document are identified as "useful resources" and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment for residents where bed rails are used. In this document, it was recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including, but not limited to, the resident's medical diagnosis, sleep habits, medications, ability to toilet self, existence of delirium, cognition, communication, mobility in and out of bed, risk of falls and potential safety risks posed by using any type of bed rail.

The clinical guidance document describes that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

In addition to providing guidance in establishing a clinical assessment where bed rails are used, the HC Guidance Document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools (the cone and cylinder tool) and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

On October 31 and November 01, 2017, Inspector #548 observed resident #031, #032 and #033's bed system with two ¼ bed rails that were raised at the head of the bed. Inspector #548 observed that there was approximately four to six inches gap between the end of the mattress and the headboard (Zone 7).

On November 02, 2017, Inspector #573 reviewed resident #031, #032 and #033's written plan of care in place, which identified the use of two ¼ bed rails for resident's bed mobility and safety. Further, upon review of resident's health care record, Inspector was unable to locate any assessment related to the use of bed rails for the residents.

On November 03, 2017, Inspector #573 spoke with the home's ADOC regarding above three resident assessments and their bed system evaluation related to the use of ¼ bed rails. The ADOC indicated that with the help of registered nursing staff all the residents were assessed (Bed Safety Assessment) related to the use of bed rails. The ADOC indicated that the home's DOC and the physiotherapist completed the bed entrapment assessment for all the resident bed systems with the bed rails. Further, the ADOC indicated that the bed safety assessment was not documented for all the residents.

On November 06, 2017, Inspector #573 reviewed resident #031, #032 and #033's completed bed safety assessments and found out that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective was not documented in the resident bed safety assessment.

During an interview on November 06, 2017, the home's DOC indicated that for all the resident's bed system with bed rails, a comprehensive resident bed safety assessment was not completed. The DOC indicated that for all the residents' bed system where the bed rails in use, the residents were assessed for the safety regarding the use of bed rails. She indicated that with the help of home's physiotherapist they completed the bed entrapment assessment by using a measuring tape. The DOC indicated to the Inspector that they did not use the cone and cylinder tool for the bed entrapment assessment as directed by the Health Canada Guidance Document. The DOC indicated that out of 60 residents only 12 bed safety assessment were documented. Further, she indicated to the Inspector #573 that the risk-benefit assessment was not documented in the residents health care record.

A Compliance Order was issued based on the severity of harm that presents "potential for actual harm" to the residents and the non-compliance scope was identified as "widespread".
(573)

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

Apr 06, 2018(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 13 day of March 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KATHLEEN SMID - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

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Service Area Office / Bureau régional de services : Ottawa