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

**Health System Accountability and Performance Division
Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 10, 2013	2013_189120_0085	H-000285-13	Follow up

Licensee/Titulaire de permis

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

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

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 29, 2013

This review is a follow-up to non-compliance identified on April 11, 12 & 18, 2013 regarding the safety of the home's beds. Directives were made on Order #001 (issued on May 14, 2013, inspection report #2013-189120-0025) for the licensee to comply by November 14, 2013. Non-compliance remains outstanding, see below for further details.

During the course of the inspection, the inspector(s) spoke with the associate administrator, director of care, registered staff and maintenance person.

During the course of the inspection, the inspector(s) toured several resident rooms and reviewed policies and procedures and associated forms and bed safety audits.

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

Findings of Non-Compliance were found during this inspection.

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 :

Where bed rails are used, steps have not been taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Non-compliance was previously identified on April 11, 2013 regarding failure to adequately ensure that entrapment zones are managed on beds where residents use bed rails.

An entrapment zone audit was conducted by home staff on May 16, 17 & 21, 2013 of all beds in the home. The results of the audit concluded that 122 out of the 167 beds failed both zone 4 (between the mattress and the end of the rail) and zone 6 (between the mattress and the head or foot board). The solution to reduce these particular zones would be to purchase new mattresses, replace the rail, cover the rail with a rail pad or insert bolsters or gap fillers. Any alterations would then have to be re-tested to confirm that the zones had been eliminated or reduced. During a tour of the home, obvious gaps between head boards and mattresses and bed rails and mattresses were observed. Some beds had mattress keepers installed to prevent the mattress from sliding, however, mattress keepers alone did not resolve zone 4 and zone 6 entrapment risks.

Documentation was provided by registered staff that 39 residents required both bed rails in the raised position when in bed for safety. Approximately 10 of these residents have a therapeutic air mattress which are inherently riskier based of their soft shell, lack of rigid edges and compression. One resident in particular was observed during the inspection to be sleeping on a therapeutic surface with both 3/4 length rails in the raised position. No gap fillers, bolsters or rail pads had been provided. It is unknown how many of the 39 residents reside on beds that have failed any zone of entrapment. According to staff, since the audit was conducted, mattresses and bed frames have been switched around.

Once the home identified the zones of entrapment that did not pass, no measures were implemented to reduce the risk of entrapment in that particular zone. The home submitted a plan which identified that specialty mattresses would be provided with bolsters, mattress keepers would be installed and that bed rails not in use would be tied down. The plan specified that residents would be assessed clinically, to determine if a rail is necessary, yet the only tool used by registered staff was a form titled "restraint assessment". The form does not guide staff in deciding what needs to be done if a rail is required to be used where it has failed one or more zones of

entrapment. Staff assessing residents have not been given any information as to which beds have failed and have not been given any education regarding entrapment zones. [s. 15(1)(b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 10th day of December, 2013

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

Ministry of Health and Long-Term Care

Ministére 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

Health System Accountability and Performance Division
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Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2013_189120_0085
Log No. / Registre no:	H-000285-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 10, 2013
Licensee / Titulaire de permis :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
LTC Home / Foyer de SLD :	HERITAGE GREEN NURSING HOME 353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ROSEMARY OKIMI

To HERITAGE GREEN NURSING HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2013_189120_0025, 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;

1. Identify all residents who currently use one or more bed rails to determine what zone of entrapment is a risk on their particular bed.
2. Assess residents to determine their specific bed rail needs using the "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings". Those identified to be on specialized therapeutic mattresses shall be assessed first, followed by all others.

3. Institute measures to mitigate the identified risk.
4. Monitor the measures that were instituted and re-evaluate to determine if the measures are effective when or if the resident's condition changes or the bed system has been changed (rail, mattress or frame).

The above directives shall be completed by January 28, 2014.

Grounds / Motifs :

1. Where bed rails are used, steps have not been taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Non-compliance was previously identified on April 11, 2013 regarding failure to adequately ensure that entrapment zones are managed on beds where residents use bed rails.

An entrapment zone audit was conducted by home staff on May 16, 17 & 21, 2013 of all beds in the home. The results of the audit concluded that 122 out of the 167 beds failed both zone 4 (between the mattress and the end of the rail) and zone 6 (between the mattress and the head or foot board). The solution to reduce these particular zones would be to purchase new mattresses, replace the rail, cover the rail with a rail pad or insert bolsters or gap fillers. Any alterations would then have to be re-tested to confirm that the zones had been eliminated or reduced. During a tour of the home, obvious gaps between head boards and mattresses and bed rails and mattresses were observed. Some beds had mattress keepers installed to prevent the mattress from sliding, however, mattress keepers alone did not resolve zone 4 and zone 6 entrapment risks.

Documentation was provided by registered staff that 39 residents required both bed rails in the raised position when in bed for safety. Approximately 10 of these residents have a therapeutic air mattress which are inherently riskier based of their soft shell, lack of rigid edges and compression. One resident in particular was observed during the inspection to be sleeping on a therapeutic surface with both 3/4 length rails in the raised position. No gap fillers, bolsters or rail pads had been provided. It is unknown how many of the 39 residents reside on beds that have failed any zone of entrapment. According to staff, since the audit was conducted, mattresses and bed frames have been switched around.

Once the home identified the zones of entrapment that did not pass, no measures were implemented to reduce the risk of entrapment in that particular zone. The home submitted a plan which identified that specialty mattresses would be provided with bolsters, mattress keepers would be installed and that bed rails not in use would be tied down. The plan specified that residents would be assessed clinically, to determine if a rail is necessary, yet the only tool used by registered staff was a form titled "restraint assessment". The form does not guide staff in deciding what needs to be done if a rail is required to be used where it has failed one or more zones of entrapment. Staff assessing residents have not been given any information as to which beds have failed and have not been given any education regarding entrapment zones. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 28, 2014

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall provide all staff who provide resident care education information from Health Canada's Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" by December 31, 2013.

Grounds / Motifs :

1. Where bed rails are used, steps have not been taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Non-compliance was previously identified on April 11, 2013 regarding failure to adequately ensure that entrapment zones are managed on beds where residents use bed rails.

A recent entrapment zone audit was conducted by home staff on May 16, 17 & 21, 2013 of all beds in the home. The results of the audit concluded that 122 out of the 145 beds failed zone 4 (between the mattress and the end of the rail) and 122 out of 145 failed zone 6 (between the mattress and the head or foot board). The solution to reduce these particular zones would be to purchase new mattresses, replace the rail, cover the rail with a rail pad or insert bolsters or gap fillers. Any alterations would then have to be re-tested to confirm that the zones had been eliminated or reduced. During a tour of the home, obvious gaps

between head boards and mattresses and bed rails and mattresses were observed. Some beds had mattress keepers installed to prevent the mattress from sliding, however, mattress keepers do not resolve zone 4 and zone 6 entrapment risks.

Documentation was provided by registered staff that 38 residents require both bed rails in the raised position when in bed for safety. Approximately 10 of these residents have a therapeutic air mattress which are inherently riskier based of their soft shell, lack of rigid edges and compression. One resident in particular was observed during the inspection to be sleeping on a surface with both 3/4 length rails in the raised position. No gap fillers, bolsters or rail pads had been provided. It is unknown how many of these 38 residents reside on beds that have failed any zone of entrapment. According to staff, since the audit was conducted, mattresses and bed frames have been switched around.

Once the zone was identified, no measures were implemented to reduce the risk of entrapment in that particular zone. The home submitted a plan which identified that specialty mattresses would be provided with bolsters, mattress keepers would be installed and that bed rails not in use would be tied down. The plan specified that residents would be assessed clinically, to determine if a rail is necessary, yet the only tool used by registered staff was a form titled "restraint assessment". The form does not guide staff in deciding what needs to be done if a rail is required to be used where it has failed one or more zone of entrapment. Staff assessing residents are not currently aware of which beds have failed and have not been given any education regarding entrapment zones.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2013

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 10th day of December, 2013

Signature of Inspector / Signature de l'inspecteur : B. Susnik

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

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