Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 18, 2017	2017_582548_0012	009563-17	Resident Quality Inspection

Licensee/Titulaire de permis

HILLTOP MANOR NURSING HOME LIMITED
82 Colonel By Crescent Smiths Falls ON K7A 5B6

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

HILLTOP MANOR NURSING HOME LIMITED
1005 ST LAWRENCE STREET P.O. BOX430 MERRICKVILLE ON K0G 1N0

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

RUZICA SUBOTIC-HOWELL (548), MEGAN MACPHAIL (551)

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): June 26, 27, 28, 29. 30, July 4, 5 and 6, 2017

The inspectors also reviewed resident health care records, observed residential areas of the home, observed a medication administration pass, relevant home policies and reviewed minutes for the Residents' Council.

Log 011358-17,Critical Incident Report# 2645-00002-17- related to a fall incident

During the course of the inspection, the inspector(s) spoke with President of the Residents' Council, the Owner/Administrator, the Director of Care, The Assistant Director of Care/RAI coordinator, the Director of Environmental Services,Director of Activation, the Office manager, registered practical nurses (RPNs), registered nurses (RNs), personal support workers (PSWs), a dietary aide,laundry aide,housekeeping, residents, and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

6 WN(s)
3 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 failed to ensure each resident had 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 notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care(MOHLTC), Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the notice, it is written that this HC Guidance Document is expected to be used as a ``best practice document``. The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. These documents referred to in the HC Guidance Document are identified as useful resources to assess individual resident needs related to the use of bed rails. One document 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) provides necessary guidance in establishing a clinical assessment where bed rails are used. The document provides guidance to for an individualized, systematic and documented approach and is intended to guide the development of resident care plans. It is identified that the population at risk for entrapment are residents who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction and acute urinary retention that would cause them to move about the bed or try to exit from the bed. The clinical decision making framework is for Individualized resident assessment for the use- not to use bed rails with the approval from the

interdisciplinary team. Input is also to be sought from the resident, family or legal guardian. The process is to include 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. Documentation of the risk-benefit assessment is required. The assessment takes into consideration numerous factors including (but not limited to): the resident's medical needs, sleeping habits, cognition and bed mobility. Diagnoses, symptoms, conditions and /or behavioural symptoms for which the use of a bed rails is being considered are to be addressed. Nursing/medical and environmental interventions are to be identified. The decision to use bed rails is to be approved by the interdisciplinary team that assessed the resident: and the effectiveness of the use of the bed rail is to be reviewed regularly. The second document titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce Risk of Entrapment" (FDA, 2006) guides an interdisciplinary group to evaluate bed systems by providing dimensional limits and test methods for measuring gaps in hospital beds.

On June 27, 2017 Inspector #551 observed an approximate three to four inch gap between the mattress and headboard of resident's #002 bed.

On June 28, 2017 Inspector #551 observed a resident #010 head of bed elevated and a pillow between the end of the plastic frame of the mattress and headboard. There was an approximate six inch gap between the mattress and the headboard. For resident #005 the inspector observed an approximate gap of four inches between the mattress and the headboard.

On July 6 Inspector #548 observed a bed in a specified room to have a three to four inch gap between the end of the mattress and headboard. Resident #010 was observed to be lying in bed, the head of bed was elevated 10 degrees with a pillow between the plastic frame that cradles the mattress and head board. With this elevation there was approximately 10 inch gap between the headboard and mattress. Affixed to the bed were three quarter rails. Resident #010 indicated that the pillow was placed in the gap as the mattress had moved down the bed frame while the resident was in the bed. It was observed that the resident could mobilize out of bed on their own. In another specified room it was observed that there was a six inch gap between the headboard and mattress.

The DOC indicated that resident #010, resident #002 and resident #005 were admitted to the home and had remained in the same bed system since their admission.

On July 6, 2017 during an interview with Inspector #548 the Director of Care (DOC) and Director of Environment Services(DES) indicated that annual entrapment testing was conducted and weekly the physical functionality of bed components are checked for stress and wear by the housekeeping and janitorial staff.

The DES indicated that the most recent bed evaluation was conducted on February 11, 2016 with a third party vendor. The DES indicated that the outside provider conducted each resident bed evaluation with him present. He explained that the outside provider had discussed with him what defined bed accessories, entrapment zones and what were the required corrective measures. He indicated that he was not aware that the majority of the bed rails were loose and made immediate strides to correct this. He indicated that he was provided a report of the testing conducted on that date. He further indicated that the home purchased a testing tool for future bed system evaluations; although he is responsible the annual evaluation had not been scheduled as yet. The DES indicated that the documentation of the inventory of beds-in-use and the testing for bed entrapment was provided to him by the outside provider. He provided to the inspector a document 'Joerns' dated February 11, 2016. He further explained that he was unaware of any pre-existing bed system evaluation conducted at the home. He also indicated that a new bed and several mattresses had recently been put to use in the home and had not been evaluated. He was not able to indicate which resident had receive the new bed system or which of the resident's received new mattresses.

The DOC indicated that there is no formalized interdisciplinary team responsible to assess resident use of bed rails. She also explain there is no risk-benefit assessment nor is there any individual resident assessment of sleep patterns and preferences, level of comfort, behaviours and other relevant factors prior to the application of bed rails. The DOC indicated that she was not aware of the requirement to do so. She did indicate that the home had a policy specific to the use of bed rails and provided this to the inspector. She indicated that she could not identify which resident is currently using the new bed nor which resident received a new mattress. Both DES and DOC indicated there is no documentation of this information.

On the 'Joerns' form each room is identified alpha-numerically. Beds are identified by manufacturer, bed model and serial number and, whether the bed is electrical or manual. Mattresses are identified by type. There are columns for: notes, a pass/fail mark, there is a section to identify if the bed has been affixed with mattress stops, an additional note section is being used for corrective actions and type of bed rail in use.

The home currently has 60 residents in three different models of beds: Carroll Echo, Joerns Care 100 and Invacare CS3 and eight mattress types: Raised Joerns, Bluefoam, Roho, Waterloo, Zenith, LAL, Flat Joerns and Spa. The document does not include zone results for each individual zone-1, 2, 3 and 4. There is no reference to zone 1- the test for the potential for head entrapment within the perimeter of the rail, zone 2 - the gap under the rail and above the mattress, zone 3- the space between the inside surface of the rail and the mattress and zone 4- the gap between the mattress and the lowermost portion of the rail. The DES explained that zones 2, 3 and 4 failed testing for 18 beds that were in use at the time.It is recorded on the form that for the beds that zones 2,3,and 4 failed and the corrective action was to tighten the loose rails. The DES indicated he tightened all of the loose screws and purchased additional hardware as required. Documentation of the purchase order was reviewed. No further testing has been conducted in the home since February 11, 2016.

The Inspector #548 and DES completed a review of the current bed/mattress inventory. A sample of rooms and beds listed on the 'Joerns' document as failing zones 2,3,4, were randomly selected with the exception of one room, by the inspector. The DES explained that the bed numbering system differed from the form and how the home identified the bed's location. He indicated that bed A is number 1 and so for. Each bed was identified by the DES as was the bed manufacturer, serial number and mattress type to the Inspector #548.

In a specified room the bed manufacturer is listed as Carroll, Bed Type- Echo with a specific serial # and Waterloo mattress. It was observed that the bed is a Carroll, Bed type-Echo, with a different serial #.

In a specified room the bed manufacturer is listed as Carroll, bed type-Echo with a specific serial# and with a Waterloo mattress. It was observed that the bed manufacturer was Joerns bed with Roho mattress and is equipped with a metal mattress stop.

In a specified room the bed manufacturer is listed as Carroll, bed type-Echo with a specific serial# and with a Waterloo mattress. What was observed was the bed manufacturer as Carroll, bed type-Echo different serial# with a Waterloo mattress.

In a specified room for resident #002 the bed manufacturer is listed as a Joerns, bed type- Care 100 with a specific serial#. What was observed was that the resident's bed was an Invacare bed type-CS3 and different serial#.

In a specified room the bed manufacturer is listed as Invacare, bed type- CS3 with a specific serial# and with a Raised Joerns mattress. The bed manufacturer and type were correct however, the mattress was identified by the DES as a TRUFIT.

During the observation of beds-in-use the DES indicated that he was not aware of the room changes or bed changes if there were any since the bed evaluation conducted in February 2016.

On July 6, 2017 during an interview with the Inspector #548 the DES indicated that several new mattresses were purchased for the home. Review of the purchase order dated December 1, 2016, invoice# 00004826 confirmed that six mattress were purchased. An additional two mattress were purchased on February 24, 2016 and March 10, 2016. On April 1, 2016 a new bed system was purchased. The DES indicated that the new bed and all eight mattresses were in use at the home however, there is no record which mattress had been replaced, nor the location of the new bed. He indicated that there were no bed evaluations conducted as a result of these changes.

A compliance order is warranted due to the potential harm and the wide spread scope of non-compliance related to residents not having been assessed or his or her bed system evaluated in accordance with evidence-based practices as well as, the homes previous non-compliance inspection #2015_285126_0030 commencing on August 4, 2015 where the Administrator indicated on August 11, 2015 that no bed system evaluation was done at the home since 2012 and that he had further indicated that several bed systems were changed and fixed following the evaluation in 2012, but no other follow-up was done since. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments.

Resident #003 is assisted in activities of daily living and requires nutritional interventions to promote wound healing.

On July 4, 2017 during an interview with the Inspector #548 the Director of Care (DOC) defined altered skin integrity to include bruising, redness, open areas and wounds. She indicated that the home's clinically appropriate assessment tool for wounds - 'Weekly Skin and Wound Evaluation' is to be conducted on a weekly basis.

The Minimum Data Set (MDS) assessment for a specified date in March 2017 identified a stage II pressure ulcer for resident #003 and on a specified day in May 2017 a pressure ulcer was identified as stage III.

The progress notes and skin and wound assessments were reviewed for a specified period of time from March 2017 to June 2017.

A progress note entry dated for a specified date in March 2017 indicated the resident #003 had developed a pressure ulcer to a specific area. Four days later it is recorded on the Weekly Skin and Wound Evaluation the pressure ulcer is staged as a level II.

On a specified day in April 2017 the same pressure ulcer is described as unstageable.There are no weekly skin and wound assessments conducted between a specified period of time in March 2017 to a specified period of time in April 2017.

On a specified day in April 2017 there is documentation describing the pressure ulcer.

Subsequently, on a specified day in May 2017 there is documentation describing the pressure ulcer to the specific area however, the wound is not assessed until sixteen days later. Almost one month passes before the next clinical assessment is conducted.

On a specified day in April 2016 another wound to a specific area is assessed on the Weekly Skin and Wound Evaluation form. From the Inspector's #548 and DOC review, no other assessments using the clinical tool are conducted of the wound after the initial assessment.

On a specified day in May 2017 on a Weekly Skin and Wound Evaluation form a the resident has another pressure ulcer on a specific area. From the Inspector's #548 and DOC review, no other assessments using the clinical tool are conducted of the wound after the initial assessment.

The Licensee failed to use a clinically appropriate assessment tool for resident #003 who was exhibiting pressure ulcers. [s. 50. (2) (b) (i)]

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 ensure a skin assessment is conducted using a clinically appropriate assessment tool for resident #003, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated:

1. A change of five (5) per cent (%) of body weight, or more, over one (1) month.
2. A change of seven and a half (7.5) % of body weight, or more, over three (3) months.
3. A change of ten (10) % of body weight, or more, over six (6) months.
4. Any other weight change that compromises the resident's health status.

Resident #001 has resided at the home for several years and requires medication intervention to maintain blood glucose levels.

Resident #001's body weight declined 7.1% between a specified period of time from April to May 2017 compared to over a three month period between February and May 2017. The resident's May 2017 weight was not charted in Point Click Care. In an interview with the Food Service Director on July 5, 2017, she indicated that it was on the paper weight sheet for May, and that the weight loss was verified.

According to a review of the resident's health care record, on a specified date in May 2017, the RD completed a consult as resident #001 refused to eat meals in the dining room. An intervention was actioned to provide a tray to the resident. There is no documentation to indicate that the weight loss between a specified period of time was assessed.

The resident's weight declined 1.6% between a specified period of time in May and June 2017. The June weight represented a body weight loss of 10% over 3 months and a loss of 10.6% over 6 months.

Resident #001's June weight status was assessed on a specified day in June 2017 by the then Acting Director of Care. No actions were taken to address the weight loss.

Resident #001's flow sheet for meal consumption from a specified period of time in May to June 2017 was reviewed. On July 5, 2017, the Director of Care indicated that if a meal intake was coded as "response not required", it meant that the resident had refused that meal. According to the flow sheet, for the time period specified above, resident #001 refused forty four (44) out of ninety (90) meals. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. Resident #005 admission body weight was recorded. Weights nine days apart on a specified days in March represented a body weight change of 16.7% from admission and a loss of 4.8% in the nine days, for total of 20.7% over 1 month.

Resident #005's weight change from February to March 2017 was assessed by the RD two (2) months later with a weight change of 21.2% between February and May 2017 (over 3 months). In her assessment, the RD noted that the admission weight may have been inaccurate, and that resident's weight has been stable for the past 2 months. Milk with meals and protein powder three times daily were implemented to assist with wound healing. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 resident's are assessed using an interdisciplinary approach, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. Every Licensee of the long-term care home shall ensure that drugs are stored in an area or medication cart and are secured and locked.

On June 27, 2017 when entering the home at 0905 Inspector #548 observed Medication Cart (West wing) to be in front of the dining room during breakfast service with no registered staff present. Upon observing the unlocked cart the ADOC proceeded to lock the cart in the presence of the Inspector. The inspector observed a registered staff member to be in the dining room with residents, away from the cart.

On the same day at 1015 hours during an interview with Inspector #548 RPN #102 indicated that she had administered medications in the dining room at 0830 hours to four residents. She indicated that she had been away from the cart and had forgotten to lock it. She indicated that she is aware of the home's policy and that all drugs are to be secure and locked in the medication cart.

At 1115 hours Inspector #548 observed the Medication Cart (West wing) to be in the hallway. Residents' medication in strips, inhalers and general stock was accessible to the inspector. No registered staff member was present. The Inspector #548 observed RPN #102 to be in the activity room administering medications to two residents prior to returning to the cart. The RPN indicated that she was aware that the cart was to be locked when not present however, had forgotten to do so. [s. 129. (1) (a)]

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 ensure all drugs stored in a medication cart are secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that the home, furnishing and equipment are kept clean and sanitary.

On June 28, 2017 Inspector #551 observed in the shared bathroom for specified room the foot rest to the commode to have debris and putty- like substance or dried gum on the commode frame.

On June 30, 2017 Inspector #548 observed that four residents share the bathroom in the specified room. The commode foot rest was observed to have hair and dark coloured debris.

On July 4, 2017 Inspector #548 observed in the shared bathroom the commode foot rest surface to be covered with hair and dark coloured debris.

On July 4, 2017 during an interview with the Inspector #548 the DOC indicated that each PSW is assigned to a number of residents and that they are expected to carbolize those residents commodes as a part of the general duties. The DOC indicated that a resident in the observed specified room used the commode for toileting needs.

The Licensee failed to ensure resident equipment is kept clean and sanitary. [s. 15. (2) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when there is no Family Council the licensee shall convene semi-annual meetings to advise such persons of the right to establish a Family Council.

It was observed that on an advertisement posted in the home dated February 8, 2017 encouraged the establishment of a Family Council.

On June 29, 2017 during an interview with the Inspector #548 a family member indicated that he/she was not aware of any communication to advise family members of the right to establish a Family Council in the home since the resident's admission for a few years.

On the same day, the Administrator indicated to Inspector #548 that he held a meeting on January 13, 2016 and had invited family members to the first Family Council meeting, on that day. There was no participant list of who attended the meeting provided to the Inspector at the time of the inspection.

The Licensee has not demonstrated that semi-annual meetings have been convened to advise such person of the right to establish a Family Council. [s. 59. (7) (b)]

Issued on this 18th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RUZICA SUBOTIC-HOWELL (548), MEGAN MACPHAIL (551)
Inspection No. / No de l'inspection :	2017_582548_0012
Log No. / Registre no:	009563-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 18, 2017
Licensee / Titulaire de permis :	HILLTOP MANOR NURSING HOME LIMITED 82 Colonel By Crescent, Smiths Falls, ON, K7A-5B6
LTC Home / Foyer de SLD :	HILLTOP MANOR NURSING HOME LIMITED 1005 ST LAWRENCE STREET, P.O. BOX 430, MERRICKVILLE, ON, K0G-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jim Parsons

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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. Develop and implement a documented interdisciplinary team assessment process for all residents with one or more bed rails in use, and for all residents for which the use of one or more bed rails are being considered. The process shall include an individual resident assessment and shall specifically include all factors, elements and conditions as outlined in the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003). As well, the process shall consider the general guidance outlined within the Treatment Programs/Care Plans section of the FDA 2003 clinical guidance document.

2. Ensure the interdisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes, which may serve as an alternative to bed rail use and the alternatives are trialed if appropriate and dependent on the resident's assessment, during a specified observation period prior to the application of any bed rails or prior to the removal from the use of any bedrails.

3. Ensure the interdisciplinary team clearly documents the final results of the assessment/reassessment, including the risk-benefit analysis and ensuing recommendation.

4. Update the written plan of care based on each resident's assessment/reassessment by the interdisciplinary team. Include all required information as specified in the FDA 2003 clinical guidance document.

5. Assess risk for entrapment of all resident beds-in-use by clearly documenting an inventory of each bed make and model and corresponding mattress, evaluating each bed system entrapment dimensional criteria for the four entrapment zones and all corrective actions.

6. Develop and deliver education to all staff who have involvement with the use of bed rails in the home with regards to the Ontario Regulation 79/10,s. 15 (1) (a), related to the assessment of the resident in accordance with the FDA 2003 clinical guidance document to minimize risk to the resident.

Grounds / Motifs :

1. The Licensee failed to ensure each resident had 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 notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care(MOHLTC), Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the notice, it is written that this HC Guidance Document is expected to be used as a ``best practice document``. The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. These documents referred to in the HC Guidance Document are identified as useful resources to assess individual resident needs related to the use of bed rails. One document 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) provides necessary guidance in establishing a clinical assessment where bed rails are used. The document provides guidance to for an individualized, systematic and documented approach and is intended to guide the development of resident care plans. It is identified that the population at risk for entrapment are residents who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction and acute urinary retention that would cause them to move about the bed or try to exit from the bed. The clinical decision making framework is for Individualized resident assessment for the use-not to use bed rails with the approval from the interdisciplinary team. Input is also to be sought from the resident, family or legal guardian. The process is to include 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. Documentation of the risk-benefit assessment is required. The assessment takes into consideration numerous factors including (but not limited to): the resident's medical needs, sleeping habits, cognition and bed mobility. Diagnoses, symptoms, conditions and /or behavioural symptoms for which the use of a bed rails is being considered are to be addressed. Nursing/medical and environmental interventions are to be identified. The decision to use bed rails is to be approved by the interdisciplinary team that assessed the resident: and the effectiveness of the use of the bed rail is to be reviewed regularly. The second

document titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce Risk of Entrapment" (FDA, 2006) guides an interdisciplinary group to evaluate bed systems by providing dimensional limits and test methods for measuring gaps in hospital beds.

On June 27, 2017 Inspector #551 observed an approximate three to four inch gap between the mattress and headboard of resident's #002 bed.

On June 28, 2017 Inspector #551 observed a resident #010 head of bed elevated and a pillow between the end of the plastic frame of the mattress and headboard. There was an approximate six inch gap between the mattress and the headboard. For resident #005 the inspector observed an approximate gap of four inches between the mattress and the headboard.

On July 6 Inspector #548 observed a bed in a specified room to have a three to four inch gap between the end of the mattress and headboard. Resident #010 was observed to be lying in bed, the head of bed was elevated 10 degrees with a pillow between the plastic frame that cradles the mattress and head board. With this elevation there was approximately 10 inch gap between the headboard and mattress. Affixed to the bed were three quarter rails. Resident #010 indicated that the pillow was placed in the gap as the mattress had moved down the bed frame while the resident was in the bed. It was observed that the resident could mobilize out of bed on their own. In another specified room it was observed that there was a six inch gap between the headboard and mattress.

The DOC indicated that resident #010, resident #002 and resident #005 were admitted to the home and had remained in the same bed system since their admission.

On July 6, 2017 during an interview with Inspector #548 the Director of Care (DOC) and Director of Environment Services(DES) indicated that annual entrapment testing was conducted and weekly the physical functionality of bed components are checked for stress and wear by the housekeeping and janitorial staff.

The DES indicated that the most recent bed evaluation was conducted on February 11, 2016 with a third party vendor. The DES indicated that the outside provider conducted each resident bed evaluation with him present. He explained that the outside provider had discussed with him what defined bed accessories,

entrapment zones and what were the required corrective measures. He indicated that he was not aware that the majority of the bed rails were loose and made immediate strides to correct this. He indicated that he was provided a report of the testing conducted on that date. He further indicated that the home purchased a testing tool for future bed system evaluations; although he is responsible the annual evaluation had not been scheduled as yet. The DES indicated that the documentation of the inventory of beds-in-use and the testing for bed entrapment was provided to him by the outside provider. He provided to the inspector a document 'Joerns' dated February 11, 2016. He further explained that he was unaware of any pre-existing bed system evaluation conducted at the home. He also indicated that a new bed and several mattresses had recently been put to use in the home and had not been evaluated. He was not able to indicate which resident had receive the new bed system or which of the resident's received new mattresses.

The DOC indicated that there is no formalized interdisciplinary team responsible to assess resident use of bed rails. She also explain there is no risk-benefit assessment nor is there any individual resident assessment of sleep patterns and preferences, level of comfort, behaviours and other relevant factors prior to the application of bed rails. The DOC indicated that she was not aware of the requirement to do so. She did indicate that the home had a policy specific to the use of bed rails and provided this to the inspector. She indicated that she could not identify which resident is currently using the new bed nor which resident received a new mattress. Both DES and DOC indicated there is no documentation of this information.

On the 'Joerns' form each room is identified alpha-numerically. Beds are identified by manufacturer, bed model and serial number and, whether the bed is electrical or manual. Mattresses are identified by type. There are columns for: notes, a pass/fail mark, there is a section to identify if the bed has been affixed with mattress stops, an additional note section is being used for corrective actions and type of bed rail in use.

The home currently has 60 residents in three different models of beds: Carroll Echo, Joerns Care 100 and Invacare CS3 and eight mattress types: Raised Joerns, Bluefoam, Roho, Waterloo, Zenith, LAL, Flat Joerns and Spa. The document does not include zone results for each individual zone-1, 2, 3 and 4. There is no reference to zone 1- the test for the potential for head entrapment within the perimeter of the rail, zone 2 - the gap under the rail and above the

mattress, zone 3- the space between the inside surface of the rail and the mattress and zone 4- the gap between the mattress and the lowermost portion of the rail. The DES explained that zones 2, 3 and 4 failed testing for 18 beds that were in use at the time.It is recorded on the form that for the beds that zones 2,3,and 4 failed and the corrective action was to tighten the loose rails. The DES indicated he tightened all of the loose screws and purchased additional hardware as required. Documentation of the purchase order was reviewed. No further testing has been conducted in the home since February 11, 2016.

The Inspector #548 and DES completed a review of the current bed/mattress inventory. A sample of rooms and beds listed on the 'Joerns' document as failing zones 2,3,4, were randomly selected with the exception of one room, by the inspector. The DES explained that the bed numbering system differed from the form and how the home identified the bed's location. He indicated that bed A is number 1 and so for. Each bed was identified by the DES as was the bed manufacturer, serial number and mattress type to the Inspector #548.

In a specified room the bed manufacturer is listed as Carroll, Bed Type- Echo with a specific serial # and Waterloo mattress. It was observed that the bed is a Carroll, Bed type-Echo, with a different serial #.

In a specified room the bed manufacturer is listed as Carroll, bed type-Echo with a specific serial# and with a Waterloo mattress. It was observed that the bed manufacturer was Joerns bed with Roho mattress and is equipped with a metal mattress stop.

In a specified room the bed manufacturer is listed as Carroll, bed type-Echo with a specific serial# and with a Waterloo mattress. What was observed was the bed manufacturer as Carroll, bed type-Echo different serial# with a Waterloo mattress.

In a specified room for resident #002 the bed manufacturer is listed as a Joerns, bed type- Care 100 with a specific serial#. What was observed was that the resident's bed was an Invacare bed type-CS3 and different serial#.

In a specified room the bed manufacturer is listed as Invacare, bed type- CS3 with a specific serial# and with a Raised Joerns mattress. The bed manufacturer and type were correct however, the mattress was identified by the DES as a TRUFIT.

During the observation of beds-in-use the DES indicated that he was not aware of the room changes or bed changes if there were any since the bed evaluation conducted in February 2016.

On July 6, 2017 during an interview with the Inspector #548 the DES indicated that several new mattresses were purchased for the home. Review of the purchase order dated December 1, 2016, invoice# 00004826 confirmed that six mattress were purchased. An additional two mattress were purchased on February 24, 2016 and March 10, 2016. On April 1, 2016 a new bed system was purchased. The DES indicated that the new bed and all eight mattresses were in use at the home however, there is no record which mattress had been replaced, nor the location of the new bed. He indicated that there were no bed evaluations conducted as a result of these changes.

A compliance order is warranted due to the potential harm and the wide spread scope of non-compliance related to residents not having been assessed or his or her bed system evaluated in accordance with evidence-based practices as well as, the homes previous non-compliance inspection #2015_285126_0030 commencing on August 4, 2015 where the Administrator indicated on August 11, 2015 that no bed system evaluation was done at the home since 2012 and that he had further indicated that several bed systems were changed and fixed following the evaluation in 2012, but no other follow-up was done since. [s. 15. (1) (a)] (548)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 16, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 18th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ruzica Subotic-Howell

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