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

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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
Apr 13, 2017	2017_627138_0009	005458-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 Russell Road OTTAWA ON K1G 5Z6

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

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 RUSSELL ROAD OTTAWA ON K1G 5Z6

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

PAULA MACDONALD (138), MEGAN MACPHAIL (551), MICHELLE JONES (655), SUSAN LUI (178)

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): March 20, 21, 22, 23, 24, 27, 28, 29, 30, 31, April 3, 4, and 5, 2017.

The following Critical Incident Inspections were conducted as part of the Resident Quality Inspection:

Log 023566-16, CIS #C595-000041-16 related to alleged abuse of a resident;

Log 026444-16, CIS #C595-000085-14 related to a resident's hospitalization with a significant change in condition;
Log 027226-16, CIS #C595-000048-16 related to a resident's hospitalization with a significant change in condition;
Log 028098-16, CIS #C595-000051-16 related to a resident's hospitalization with a significant change in condition;
Log 029824-16, CIS #C595-000052-16 related to alleged abuse of a resident;
Log 031054-16, CIS #C595000054-16 related to a resident's hospitalization with a significant change in condition;
Log 031462-16, CIS #C595-000056-16 related to alleged abuse of a resident;
Log 034450-16, CIS #C595-000062-16 related to a resident's hospitalization with a significant change in condition;
Log 035432-16, CIS # C595-000063-16 related to controlled substance missing/unaccounted;
Log 002331-17, CIS #C595000008-17 related to a resident's hospitalization with a significant change in condition and;
Log 002796-17, CIS #C595-000014-17 related to controlled substance missing/unaccounted.

During the course of the inspection, the inspector(s) spoke with the Chief Operating Officer, Director of Nursing Operations (DNO), Director of Support Services (DSS), Director of Clinical Practice, Manager of Sub-Acute Care, Managers of Resident Care, Director of Community Outreach and Programming, Personal Support Worker Supervisors, Food Service Supervisors, Manager of Support Services, RAI Coordinator, Registered Nurses (RN), a Wound Care Champion, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food and Nutrition Aides, Housekeeping Aides, an Occupational Therapist (OT), the Chair of the Family and Friends Council, the Clinical Pharmacist Consultant, the Resident Care Liaison, a Recreation therapist, the Performance Improvement Consultant, the President of the Community Resident's Council, a member of the Community Resident's Council, the past President of the Community Resident's Council, the President of the Veterans Resident's Council, Family Members, and Residents.

During the course of the inspection, the inspector(s) completed a tour of resident areas, observed medication storage areas, observed resident care, observed meal and snack services, observed medication administration, reviewed a portion of the nursing staff schedule, reviewed medication incident documentation, reviewed Community and Veteran Resident's Councils meeting minutes, reviewed resident

health records, reviewed staff training records, reviewed home's menu cycle, reviewed a supervisor's report, reviewed wheelchair cleaning documentation, reviewed relevant home policies, protocol and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **6 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. On August 21, 2012, a notice 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 notice, it is 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 is 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 right to participate in the care planning process, the resident's medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. The document further indicates 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.

On March 21 and 22, 2017, two partial length bed rails are observed to be raised at the head of the bed in most resident rooms. It was noted that not all mattresses fit the bed frame, including for:

Resident #013: A hands-length gap was noted between the end of mattress and the headboard and the end of the mattress and the footboard, and from the foot of the bed, the gap between the right bed rail was greater than the left.
Resident #001 and #041: A 3-4 inch gap between the end of the mattress and the headboard and the end of the mattress and the footboard was noted.
Resident #008 and #004: A greater than four inch gap between the end of the mattress and the foot board was noted.
Resident #040: A greater than fist length gap was noted between the end of the mattress and the footboard. A rolled up blanket, that did not completely fit the length of the mattress, was placed in the gap, leaving the round tubing ends exposed.
Resident #014: A two-hands width space between the end of the mattress and the head board and a greater than one hands width space between the end of the mattress and the foot board was noted.

These observations led to the inspection into the home's bed system evaluations.

The Director of Nursing Operations (DNO) indicated that in 2012, the home undertook a least restraint policy review that included the sourcing of new beds and removal of the bed rails from the bottom of residents' beds in order to reduce the number of potential zones of entrapment. The standard was that all beds would have two half-length bed rails at the head of the bed and any new beds purchased would be Joerns brand.

According to the Director of Support Services (DSS), since 2014, forty one Joerns beds have been purchased. The DSS indicated that three different types of beds are used in the home: Joerns, Stryker and Bertec, and that the half-length bed rails used are the

make and model original to the bed system. In total, the home has 450 beds that each have half –length bed rails.

The health care records of resident #013, #001, #041, #008, #014, #004 and #040 were reviewed. The use of bed rails was located in the MDS and/or the written plan of care. No assessments related to the use of bed rails for these seven residents were located.

RNs #134 and #123 indicated that the standard was to have two partial bed rails at the head of the bed for all residents, and that no further assessment related to the use of bed rails was completed unless the full bed rails were being considered. [s. 15. (1) (a)]

2. Further, the document, "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" is expected to be used as best practice to prevent resident entrapment when bedrails are used.

Again, as indicated previously, the DNO indicated that in 2012, the home undertook a least restraint policy review that included the sourcing of new beds and removal of the bed rails from the bottom of residents' beds in order to reduce the number of potential zones of entrapment. The standard was that all beds would have two half-length bed rails at the head of the bed and any new beds purchased would be Joerns brand.

According to the DSS, since 2014, forty one Joerns beds have been purchased. The DSS indicated that three different types of beds are used in the home: Joerns, Stryker and Bertec, and that the half-length bed rails used are the make and model original to the bed system. In total, the home has 450 beds that each have half –length bed rails.

The home was unable to produce any record to indicate that any of the bed systems had been evaluated since 2012 such as when a new resident was admitted to the home or when a component of the resident's bed system was modified.

According to OT #135, many residents in the home have therapeutic mattresses on their beds and while it is the OT's responsibility to assess the resident for a non-standard mattress, no further formal bed system evaluation, including potential zones of entrapment, is conducted. A list provided by the Director of Community Outreach and Programming which includes the OT department indicated that eighty residents were using therapeutic mattresses.

On April 3, 2017, the DNO indicated that staff would initiate an assessment to evaluate

why the resident was using the bed rails, the risks associated with the use of bed rails and would assess the bed system for zones of entrapment, as no current resident assessment with regards to the use of bed rails and bed system evaluation existed.

The severity of harm related to resident's bed assessment and risk of potential zone of entrapment was determined to be "potential for actual harm". The scope was identified as "widespread" as the residents using bed rails were not assessed, neither was the bed systems evaluated and steps were not taken into consideration to prevent resident entrapment. [s. 15. (1) (b)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Resident #049 has dementia and has been known to wander and exhibit sexually uninhibited behavior, including touching other residents sexually.

Review of Critical Incident Report (CIR) indicated that in July 2016, staff heard yelling, and proceeded to the room of resident #050, where they observed resident #049 with his/her hand under the night clothes of resident #050. Resident #050's brief was observed to be intact and fastened. Resident #049 was immediately removed from the room, and one to one monitoring was initiated for resident #049. The CIR indicates that the incident was investigated and it was determined that PSW #136 failed to follow resident #049's plan of care, in that she did not follow resident #049 to the neighbouring unit to redirect the resident back to the resident's room.

Resident #049's plan of care in place at the time of the incident for Sexual Disinhibited Behaviours(Verbal or Physical) indicates that the resident is to be checked every 15 minutes, and be redirected if heading towards other residents' rooms. It further states that one on one close monitoring can be initiated when needed.

Inspector #178 interviewed Manager of Resident Care #116 on April 3, 2017, who indicated that PSW #136 did not follow the resident's plan of care for this incident because she did not follow the resident and redirect the resident back to the resident's own room when s/he wandered onto the neighboring unit.

PSW Supervisor #120 indicated on April 4, 2017 that PSW #136 received a letter of discipline because she did not follow the plan of care for this incident when she failed to check the resident every 15 minutes and failed to follow the resident to the neighbouring unit to redirect the resident back to the resident's own room. PSW Supervisor #120 indicated that she was able to confirm this by viewing surveillance video from the incident.

Review of a Supervisor's Report for the incident, indicates that PSW #136 was provided a verbal warning discipline as a result of failing to follow direction in a resident's plan of care. The report indicates that camera footage confirmed PSW #136 failed to perform 15 minutes checks on the resident as required, and failed to investigate and retrieve the resident after the resident went through the fire doors onto the neighbouring unit.

Inspector #178 interviewed PSW #136 on April 4, 2017, who indicated that on the date of the incident that resident #049 was agitated and wandering, and she had done everything she could to meet the resident's needs and redirect the resident back to his/her room as per the plan of care, but she was the only PSW on the unit, when there would normally be two PSWs. PSW #136 indicated that she was providing care to another resident at the time resident #049 wandered onto the neighbouring unit.

During an interview with PSW Supervisor #120 on April 4, 2017, she confirmed that the unit was short one PSW that shift, due to a bereavement leave which could not be replaced, but that there was an RPN present on the unit who could provide assistance to PSW #136.

023566-16 [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care for resident #049 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation requires the licensee of a long-term care home to institute or otherwise put in place any plan, policy, protocol, procedure, strategy, or system; that the plan, policy, protocol, procedure, strategy, or system, is complied with.

In accordance with this section and section 30 and 48 of the same regulation, the licensee is required to have developed and implemented a skin and wound care program that also has a skin and wound care policy that is complied with.

Inspector #551 reviewed resident #010's health care record and noted that the resident currently had a stage 4 pressure ulcer with specific measurements. According to the health care record, the open area progressed to a stage 4 ulcer from when it was first identified in February 2017, at which time the area was identified by a PSW and reported to the RN.

Inspector #655 spoke with several registered nursing staff regarding skin and wound care. Each of the registered nursing staff members indicated to Inspector #655 that the home's wound care champion would be consulted when a wound or ulcer is not healing. The same registered nursing staff identified RN #163 as the wound care champion in the home. Further, the home's policy titled "Skin and Wound Care Program" (June 23, 2011) states: "The Wound Care Champion, or delegate will be notified by email and will work with the unit's registered staff to provide guidance on the assessment, plan of care, and management of all alterations in skin integrity that are greater than a Stage 2".

Inspector #655 further reviewed resident #010's health care record and was unable to locate any documentation to indicate that the wound care champion had been consulted with respect to the progression of a stage 4 pressure ulcer for resident #010.

Inspector #655 spoke with RN #163, who indicated that she is considered to be the primary wound care champion at this time, and reviewed the policy document titled "Skin and Wound Care Program" (June 23, 2011). RN #163 indicated to Inspector #655 that she had never before seen the Stage 4 pressure ulcer on resident #010; nor had she been consulted about resident #010's ulcer care.

Inspector #655 also reviewed resident #025's health care record as the resident was admitted to the home in summer of 2016 with a stage 3 ulcer. The inspector was unable to locate any documentation indicating that a wound care champion had been involved in the care of resident #025's ulcer.

Inspector #655 then spoke with the Director of Clinical Practice regarding the skin and wound policy. The Director of Clinical Practice confirmed that a wound care champion is expected to be consulted, as per the policy, for any skin alteration, including a pressure ulcer, when it is greater than Stage 2. The Director of Clinical Practice acknowledged that a lack of documentation by the wound care champions in the residents' health care record would be an indication that a wound care champion had not been consulted.

As such, the licensee failed to ensure that the policy "Skin and Wound Care Program" (June 23, 2011) was complied with as it relates the role of the wound care champion(s) with regards to any alteration in skin integrity greater than Stage 2, such as resident #010's stage 4 pressure ulcer and resident #025's stage 3 ulcer. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the relevant "Skin and Wound Program" policy is complied with as it relates to the skin and wound care for residents #025 and #010, to be implemented voluntarily.

WN #4: 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 has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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.

A) Inspector #655 reviewed resident #010's health care record and noted that the resident currently had a stage 4 pressure ulcer with specific measurements. According to the health care record, the open area progressed to a stage 4 ulcer from when it was

first identified in February 2017, at which time the area was identified by a PSW and reported to the RN. Inspector #655 further reviewed the resident's health care record and was unable to determine if the assessment was completed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Inspector #655 interviewed RPN #121 regarding resident #010's pressure ulcer. RPN #121 was unaware of any clinically appropriate assessment instrument specifically designed for skin and wound. RPN #121 indicated to the inspector that all skin and wound assessments were completed in the progress notes and acknowledged that the progress notes did not include any prompts related to a standardized assessment process.

Further, RN #123 also indicated to Inspector #655 that while resident #010's ulcer was assessed, it was not assessed with a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment until March 16, 2017. RN #123 further indicated that not all registered nursing staff use the existing clinically appropriate assessment instrument designed for skin and wound assessment.

B) Inspector #655 also reviewed resident's #025's health care record as the resident was admitted to the home in the summer of 2016 with a stage 3 ulcer. Inspector #655 was unable to confirm that the wound assessment was completed with a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment until March 2017.

Inspector #655 spoke with RPN #122 regarding skin and wound assessments. RPN #122 stated that skin and wound assessments are completed and documented in the progress notes of the health care record. RPN #122 stated that she was not aware of the use of any clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

C) Inspector #655 reviewed resident #030's health care record and noted that the first observation of altered skin integrity was made in March 2016. On review of the progress notes, Inspector #655 noted several incidents of the recurring pressure ulcer. According the progress notes, an open area on resident #030 (ranging from Stage 1- Stage 2) was observed in April 2016, November 2016, December 2016, February 2017 and March 2017. Again, the inspector was able to determine that the ulcer was assessed but was unable to confirm from the health care record that the skin and wound assessments on

the residents were completed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Inspector #655 spoke with RN #165 regarding resident #030's ulcer. RN #165 stated that the resident's ulcer is assessed by registered nursing staff on a weekly basis and that each assessment is documented using a progress note. According to RN #165, there is no assessment instrument specifically designed for skin and wound assessment in use by registered nursing staff in the home at this time. RN #165 explained that an assessment instrument had been available for use in the electronic health record system; but that the instrument was removed so that it could be updated.

D) In September 2016, a CIR was submitted to the Director under the Long-term Care Home Act (2007), related to an incident involving resident #068 in which resident #068 suffered further injury related to a skin integrity issue that occurred in August 2016.

According to the CIR, resident #068 was found by staff with an injury that included a skin integrity issue. Six days later, resident #068 was diagnosed with an infection and a treatment was initiated. Resident #068 was sent to the hospital eleven days later for further assessment. While in hospital, the resident had underwent interventions that significantly changed the resident health care condition.

Inspector #655 reviewed resident #068's health care record and noted that the skin integrity issue was assessed following the incident that occurred in August 2016. The inspector, however, was unable to confirm from the health care record that the skin and wound assessment was completed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Inspector #655 spoke with the wound care champion, RN #163, regarding resident #068. RN #163 stated that all skin and wound assessments were documented in the progress notes and not completed with a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Inspector #655 also spoke with RN #159 who stated that she was not aware of a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment that could have been used to assess the condition of resident #068 following the incident that took place in August 2016.

Inspector #655 spoke with the Director of Nursing Operations who stated that a clinically

appropriate assessment instrument is expected to be used by a member of the registered nursing staff when an alteration in skin integrity is identified.

Inspector #655 also spoke with the Director of Clinical Practice regarding skin and wound assessments. The Director of Clinical Practice explained that the home utilizes the "Bates Jensen" instrument, specifically designed for skin and wound assessment. According to the Director of Clinical Practice, the "Bates Jensen" instrument is designed to be used for any type of alteration in skin integrity.

The licensee failed to ensure that resident #010, #025, #030, and #068's skin assessments by the registered nursing staff were completed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [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 to ensure that residents, including resident #010, #025, #030, and #068, receive 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a process to ensure that food service workers and other staff assisting residents are aware of the residents' preferences.

According to dietary aide #103, each resident has an index card that outlines the resident's diet and other special considerations and forms the dietary kardex.

On March 20 and 27, 2017, it was observed that a meal time choice was offered only to a limited number of residents who eat in the Country Kitchen of Rideau 1 South which is a secure unit.

Residents who were not offered a meal time choice included resident #060, 061, 062, 063 and 065.

The written plan of care for each of these residents was reviewed and directs staff to refer to the dietary kardex at the point of service for additional dietary information. No food preferences for any of these residents were found listed in the written plan of care or on the dietary kardex.

On March 22, 2017, twenty two residents had an index card in the dietary kardex and only three of twenty two listed any specific food preferences. [s. 73. (1) 5.]

2. The licensee has failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required

by the resident.

On March 27, 2017, resident #061 received an entrée consisting of a chicken sandwich and ceasar salad at 1240 hours and did not attempt to feed self. At 1246 hours, a volunteer passed by and put a piece of the resident's sandwich in the resident's hand which the resident did not consume. At 1248 hours, the resident was making a sipping motion into an empty beverage cup which was not replenished. At 1253 hours, the resident was reapproached by the volunteer who sat with the resident and assisted the resident to initiate his/her meal.

A review of resident #061's health care record indicates that the resident is ordered supplemental Resource 2.0 120ml four times daily and that the resident's weight did decline 8% in the past year.

On March 27, 2017, residents #063 and #065 received their entrees consisting of pureed beef, whipped potatoes and pureed green beans at approximately 1240 hours . Neither resident attempted to feed themselves and were assisted by an unidentified male PSW. At 1254 hours, the PSW left the residents and began serving tea and coffee at another table. At this time, approximately half of both of the residents' entrees remained uneaten. At 1256 hours, PSW #132 sat with the residents and fed them one bite each. Resident #065 was then removed from the dining room. The resident returned at 1306 hours and was not assisted to eat anymore of his/her meal until s/he was removed from the dining room approximately ten minutes later. From 1256 until 1303 hours and from 1305 until 1315 hours, resident #063 sat at the table with half of an uneaten entrée and no assistance was provided. The resident made no attempt to feed self.

According to resident #063's health care record, the resident consumes a puree texture, thickened liquids diet and requires total assistance for feeding. The resident's most recent weight represents a BMI of 13.6. The resident's weight has declined 3.5% in three months, 17.1% in six months and 25.7% in the last year.

According to resident #065's health care record, the resident consumes a puree texture diet and requires total assistance for feeding. The resident's most recent weight represents a BMI of 17.6. The resident's weight has declined 3.7% in three months, 11.9% in six months and 22.2% in the last year. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents who require assistance with eating or drinking are only served a meal when someone is available to provide assistance, to be implemented voluntarily.

WN #6: 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. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies, is secure and locked, and protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy.

On March 20, 2017 at approximately 1100 hours, Inspector #178 observed:
-In the west tub room on Gatineau 1 South, a basket on the counter containing prescription creams for resident #055, 1% Hydrocortisone powder in 1% Clotrimaderm cream.
-In the east shower room on Gatineau 1 South, a basket containing prescription cream

for resident #056, Betaderm cream.

On March 21, 2017, Inspector #655 observed an open plastic bin full of prescription creams including hydrocortisone and clotrimaderm. The plastic bin was unlocked and sitting on a counter inside the tub room.

On March 22, 2017, Inspector #655 observed prescription clotrimaderm cream in resident #011's washroom.

On March 23, 2017, at 1550 hours, Inspector #178 observed in the east tub room on Gatineau 1 South, a basket on the counter containing prescription creams for resident #055, 1% Hydrocortisone powder in 1% Clotrimaderm cream. No resident or staff were present.

On March 28, 2017 at 1030 hours, Inspector #178 observed in the Ottawa 1 West tub room, a basket on the counter containing prescription creams for residents: #057, Emo-cort Hydrocortisone 2.5% cream; #058, 1% Hydrocortisone powder in 1% Clotrimaderm cream; #059, Betaderm 0.1% scalp lotion.

During an interview with RPN #125 on March 20, 2017, she indicated to Inspector #178 that prescription creams are stored in the tub or shower rooms during the day so PSWs can access them to apply them when providing residents' care. After their shift, the PSW returns the creams to the registered staff, who returns them to the medications room.

During an interview with RPN #126 on March 28, 2017, she indicated to Inspector #178 that the medicated creams are always stored in the tub and shower rooms, in a locked cupboard, with the key hanging on the outside of the cupboard.

During an interview with Manager of Resident Care #116 on March 29, 2017, she indicated to Inspector #178 that the prescription creams are provided to the PSWs at report so they can apply the creams during resident care, and it is expected that they be returned to registered staff after use and stored in the locked medication cart or locked medication room. Manager of Resident Care #116 indicated that prescription creams are not supposed to be stored in tub and shower rooms, and staff other than registered staff can access the tub and shower rooms using a code. [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 to ensure that drugs, including prescription creams, are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies, is secure and locked, and protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

A) During an interview on March 21, 2017, resident #020 was identified by a staff member to have an indwelling catheter in place.

Inspector #655 reviewed resident #020's health care record. According to the health care record, resident #020 uses of an indwelling catheter. In the current care plan, it is indicated that resident #020 was positive for a specific infection. Also, in the same care plan, it is indicated that resident #020 has a history of recurrent infections. It is further stated in the care plan that resident #020s' urinary catheter drainage bag was to be capped when not in use, and stored in a specified labeled container in the residents' room, located on a shelf near the toilet.

On March 29, 2017, Inspector #655 observed resident #020s' night drainage bag to be hanging on a towel rod in the residents' bathroom. The tubing was observed to be uncapped at the time of the observation. The closed system of the catheter drainage bag

was not maintained; and the catheter drainage bag was not stored in accordance with the plan of care.

During interviews on March 29, 2017, PSWs #169 and #173 indicated to Inspector #655 that the catheter drainage bag tubing is expected to be capped when it is not in use by the resident.

On the same day, PSW #173 indicated that resident #020s' catheter drainage bag was not stored appropriately at the time of the above-noted observation. PSW #173 indicated to Inspector #655 that catheter drainage bags are not always stored appropriately; and further explained that if she had observed any catheter drainage bag to be hanging with the tubing uncapped, it would be her practice to notify the nurse, discard the uncapped unit, and replace it with a new drainage bag system in order to minimize the risk of infection.

During an interview on March 30, 2017, RPN #158 indicated to Inspector #655 that resident #020 has a history of recurrent infections. During the same interview, RPN #158 indicated to Inspector #655 that she had never seen a cap that could be used on the end of the tubing of catheter drainage bag systems, such as the one used for resident #020. RPN #158 further indicated that she does believe these types of caps are stocked for use in the home.

B) On March 21, 2017, Inspector #178 observed a catheter drainage bag belonging to resident #022 to be hanging on a grab rail in the residents' bathroom; with the end of the tubing uncapped. Then, on March 29, 2017, at 1219 and again at 1510, Inspector #655 observed the night catheter drainage bag belonging to resident #022 to be hanging on a grab rail next to the toilet in the resident's room, with the tubing uncapped. Again, on March 30, 2017, Inspector #655 observed the night catheter drainage bag belonging to resident #022 to be hanging on a grab rail next to the toilet in the resident's room, with the tubing uncapped – a closed system had not been maintained.

Inspector #655 reviewed the health care record belonging to resident #022. Resident #022 is to use an indwelling catheter. According to the care plan, resident #022 uses two types of urinary catheter drainage bags, one for day and one for evening.

During an interview on March 30, 2017, PSW#160 indicated to Inspector #655 that resident #022's catheter drainage bag is changed from a night bag to a leg bag routinely. According to PSW #160, when one bag is removed, the bag is to be rinsed with water

and then vinegar; and the tubing ends are sanitized using an alcohol swab. PSW #160 indicated to Inspector #655 that after the end of the tubing of the catheter drainage bag system is sanitized, it should be capped.

During an interview on the same day, RN #159 also indicated to Inspector #655 that the end of the tubing on the catheter drainage bag system is expected to be capped when not in use by the resident.

C) On March 21, 2017, Inspector #178 observed that a catheter drainage bag belonging to resident #025 was hanging on a grab rail in the residents' room, with the tubing uncapped.

Inspector #655 reviewed the health care record belonging to resident #025. According to the health care record, resident #025 uses an indwelling catheter. According to the care plan, dated March 12, 2017, resident #025 uses two types of urinary catheter drainage bags with routine changes.

Over the course of the inspection, staff indicated to Inspector #655 that the tubing of catheter drainage bag systems are to be capped when not in use by the resident. During an interview on March 29, 2017, PSW #173 indicated to Inspector #655 that this is done in order to minimize the risk of infection.

On March 29, 2017, at 1209 hours and again at 1515 hours, Inspector #655 observed the night urinary catheter drainage bag belonging to resident #025 to be hanging on the towel rod in resident #025's bathroom, with the tubing uncapped.

On March 30, 2017, Inspector #655 observed the same type of catheter drainage bag belonging to resident #025 to be hanging on a grab rail next to the toilet in the residents' bathroom, with the tubing uncapped. On April 3, 2017, the tubing on resident #025's catheter drainage bag remained uncapped when it was not in use by the resident – a closed system had not been maintained.

During an interview on March 30, 2017, the Manager of Infection Prevention and Control was unable to speak to whether the tubing of catheter drainage bag systems are expected to be capped.

During an interview on April 4, 2017, the Director of Nursing Operation indicated to Inspector #655 that urinary catheter drainage bags are expected to be capped when they

are not in use by the resident; and indicated that it is common for the caps to go missing.

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program as it relates to catheter care for residents #020, #022, #025. [s. 229. (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 compliance to ensure that staff participate in the implementation of the infection prevention and control program when they provide catheter care for resident #025, #020, and #022, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to comply with section 9. (1) 2. of the regulation in that the licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Inspector #655 observed on March 20, 2017 at 1038 hours that the door leading to the staff room on Ottawa 1 behind the main nurse's station was observed to be closed but unlocked. This door is accessible to residents as the nursing station is not closed off. It was noted that once through the door there were three other unlocked doors, two of which led to locker rooms and the other to a bathroom. The Inspector noted that there

was no resident-staff communication and response system (call bell system) in the area and there were no staff in the area providing supervision at the time of the observation. Inspector #655 again observed the following day on March 21, 2017 at 1545 hours, and again on March 22, 2017 at 1512 hours, that the same door was closed but remained unlocked. Again, there were no staff in the area supervising the door at the time these observations were made.

Inspector #655 went back to nurse's station on Ottawa 1 on March 23, 2017 at 1500 hours. At this time the inspector spoke with RPN #102 who stated that the door leading to the staff room on the unit is not equipped with a lock and, therefore, is not kept locked when not supervised by staff. RPN #102 also stated that the doors to the two locker rooms and bathroom within the door to the staff room are also kept unlocked. RPN #102 confirmed that the staff room on the unit was not intended for resident use.

Further, Inspector #655 observed on March 20, 2017, that the door to the beauty salon/barber shop was propped open with a door stop when it was not being supervised by staff. The Inspector observed that there was no call bell in the beauty salon/barber shop. The Inspector also made several observations throughout the course of the inspection in which the door to the beauty salon/barber shop was not locked and not supervised by staff.

Inspector #138 spoke with the Manager of Support Services on March 27, 2017, regarding the door to the staff room on Ottawa 1. The Manager of Support Services stated that the doors to the staff rooms on the units can not be locked as the doors are not equipped with locks. He further added that the homes plan to add locks to these doors in the near future.

Inspector #138 also spoke with the Director of Support Services on March 30, 2017, regarding the doors to the staff rooms as well as the door to the beauty salon/barber shop. The Director of Support Services stated that home will address these concerns. [s. 9. (1) 2.]

WN #9: 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 has failed to ensure that that the home, furnishings and equipment are kept clean and sanitary.

On March 21, 2017, inspector #655 observed unidentified debris and stains on the frame and seat cushion of resident #020's wheelchair.

On March 22, inspector # 655 observed debris and dried liquids on the frame, seat, and seat belt of resident #041's wheelchair.

On March 27, 2017, inspector #178 observed stains on the seat cushion and some dried debris on the frame of resident #020's wheelchair.

On Mar 27, 2017, inspector #178 observed debris and dried liquids on the wheelchair frame and armrests, and a small spot of dried food on the seatbelt of resident #041's wheelchair.

On Mar 28, 2017, PSW #124 accompanied inspector #178 to observe resident #041's wheelchair. Debris and dried liquids were still visible on the wheelchair frame and armrests. PSW #124 agreed with the inspector that resident #041's wheelchair was not clean. PSW #124 indicated that wheelchairs are cleaned by the night staff, who clean a certain number of wheelchairs each night.

On March 28, 2017, PSW #113 accompanied inspector #178 to observe resident #020's wheelchair, which was soiled with dust and debris on the bottom rails, and white food staining on the seat cushion. PSW #113 agreed that resident #020's wheelchair was not clean. PSW #113 indicated that general cleaning of the wheelchairs is done by a

contracted company, but that if staff observe a wheelchair to be dirty in between cleanings, they are to spot clean the wheelchair. PSW #113 further indicated that if the seat cushion cover is soiled, the night staff will take off the cover and wash it and hang it to dry overnight.

On March 29. 2017, PSW Supervisor #120 accompanied inspector #178 to observe resident #041's wheelchair. The armrests and frame of the wheelchair appeared to have been cleaned since last observed by inspector #178 on March 28, 2017. However the spot of dried food remained on the seatbelt.

On March 29, 2017, PSW Supervisor #119 accompanied inspector #178 to observe resident #020's wheelchair. Dried dust and debris was visible on the wheelchair frame, and dried white food stains were visible on the seat cushion cover. A family member of resident #020' was present at the time who indicated that the resident's seat cushion cover often becomes soiled with food, so s/he will sometimes change the cover and take the soiled cover home to wash it. PSW Supervisor #119 agreed with the inspector that resident #020's wheelchair was unclean.

On March 29, 2017, Occupational Therapist (OT) #139 indicated that wheelchairs are cleaned by night PSW staff, although she was unsure of the cleaning schedule. OT #139 indicated that in addition to the regular cleaning routine by PSWs, wheelchairs are cleaned by a contracted company twice a year, using a pressure washer.

On March 29. 2017, PSW Supervisors #119 and #120 indicated that the night shift PSWs on every unit are assigned certain wheelchairs to clean each night, using a steam cleaner. Using this system, each resident's wheelchair is cleaned a minimum of once weekly. If something is spilled on a wheelchair in between the weekly cleanings, it should be spot cleaned at the time. If the seat cushion cover becomes soiled, it should be removed, washed and hung to dry. The PSW who completes the nightly assigned cleaning, documents the cleaning by initialing on the list of wheelchairs to be cleaned on each unit. This documentation sheet is kept in a binder on each unit. PSW Supervisor #120 showed the inspector the record of resident #041's wheelchair cleaning for March, which was initialed indicating that the resident's wheelchair was cleaned on March 1, 8, and 22, and was due to be cleaned again on the night of March 29, 2017. PSW Supervisor #119 was unable to locate the record of wheelchair cleaning on resident #029's unit for March 2017. [s. 15. (2) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available.

The lunch meal service, in the Country Kitchen of Rideau 1 South which is a secure unit, was observed on March 20 and 27, 2017.

According to the menu, on Monday, March 20, 2017, chicken noodle soup, crackers/bread and pureed bread and tea/coffee were listed as planned menu items. On Monday, March 27, 2017, chicken rice soup was listed as a planned menu item.

It was noted that soup was not offered to all residents, specifically on March 20, 2017, resident #060, 061, 062, 063 and 064, and on March 27, 2017, resident #060 and 061 were not offered soup as part of the lunch meal.

On March 20, 2017 at 1315 hours, resident #060's entrée was cleared and the resident was escorted out of the dining room. The resident had been served a pork sandwich and macaroni salad and ate bites only. The resident was not offered dessert.

The written plans and dietary kardex for each of these five residents were reviewed, and there was no indication that these residents are not to be offered soup as part of the lunch meal. According to the dietary kardex, resident #060 is to receive his/her soup in a mug and residents #063 and 064 are to receive pureed, thickened soup

On March 20, 2017, none of the residents were offered crackers or bread/pureed bread, or tea/coffee with the lunch meal. [s. 71. (4)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

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,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that residents' linens are changed at least once a week and more often as needed.

On March 20, 2017, Inspector #178 observed resident #025 in bed. A strong odour of urine was noted within the resident's room.

On March 22, 2017, Inspector #178 observed resident #025's bed to be made, with a wool afghan on top. The inspector noted a strong urine odour around the bed, particularly from the wool afghan. Resident #025 was not present in the room.

On the afternoon of March 27, 2017, Inspector #178 noted a faint urine odour around resident #025's bed. The bed was not made, and the inspector observed the resident's bottom sheet to be soiled with what appeared to be urine staining and a few small brown smears around the centre of the bed. The resident was present in the room, but was in the wheelchair at the time.

On the morning of March 28, 2017, Inspector #178 observed resident #025's bed to be made, with a wool afghan on top. The inspector noted a strong urine odour coming from the bed, in particular the wool afghan. Inspector #178 pulled back the blankets of the bed and observed the same soiled bottom sheet that had been observed on the bed the prior afternoon. The resident was not present in the room. PSW #114 accompanied the inspector into the room and agreed that there was a strong urine odour around the bed, and that the bottom sheet was soiled and should have been changed. PSW #114 indicated that residents' linen is supposed to be changed at least twice a week on the resident's bath day, and also whenever it is soiled or if there is an odour. PSW#114 indicated that there is always sufficient bed linen available on the unit.

During an interview on March 29, 2017, with Manager of Resident Care #116, she indicated that resident's linen should be changed at least twice weekly on bath days, and also whenever the linen is soiled.

On March 29, 2017, Inspector #178 observed resident #025's bed to be made with clean linen. [s. 89. (1) (a) (i)]

Issued on this 13th day of April, 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) :	PAULA MACDONALD (138), MEGAN MACPHAIL (551), MICHELLE JONES (655), SUSAN LUI (178)
Inspection No. / No de l'inspection :	2017_627138_0009
Log No. / Registre no:	005458-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 13, 2017
Licensee / Titulaire de permis :	THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE 1750 Russell Road, OTTAWA, ON, K1G-5Z6
LTC Home / Foyer de SLD :	THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE 1750 RUSSELL ROAD, OTTAWA, ON, K1G-5Z6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Akos Hoffer

To THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE, 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 :

The licensee is ordered to:

1. Re-evaluate all bed systems where bed rails are used in the home, in accordance with evidence-based practices. All reassessment are to be documented.

2. Establish and implement a process for ensuring that any bed system failures are addressed immediately by taking the necessary corrective actions. All actions taken to address bed system failures are to be documented.

3. Develop and implement a documented multidisciplinary team assessment process for all residents with one or more bed rails in use (including partial rails), 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.

4. Ensure that the multidisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes, which may serve as alternative to bed rail use, and that the interventions or changes 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 use of any bed rails.

5. Ensure that the multidisciplinary team reassesses residents with one or more bed rails in use, at a minimum, whenever there is a change in the resident's health status.

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

7. Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team. Include all required information as specified in the FDA 2003 clinical guidance document, such as related to the use of bed rails for a medical symptom or condition vs. bed rails used for a resident's mobility and/or transferring.

8. Develop and deliver education to all staff who have involvement with the use of bed rails in the home with regards to 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. On August 21, 2012, a notice 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 notice, it is 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 is 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 right to participate in the care planning process, the resident's medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. The document further indicates 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.

On March 21 and 22, 2017, two partial length bed rails are observed to be raised at the head of the bed in most resident rooms. It was noted that not all mattresses fit the bed frame, including for:
Resident #013: A hands-length gap was noted between the end of mattress and the headboard and the end of the mattress and the footboard, and from the foot of the bed, the gap between the right bed rail was greater than the left.

Resident #001 and #041: A 3-4 inch gap between the end of the mattress and the headboard and the end of the mattress and the footboard was noted.
Resident #008 and #004: A greater than four inch gap between the end of the mattress and the foot board was noted.
Resident #040: A greater than fist length gap was noted between the end of the mattress and the footboard. A rolled up blanket, that did not completely fit the length of the mattress, was placed in the gap, leaving the round tubing ends exposed.

Resident #014: A two-hands width space between the end of the mattress and the head board and a greater than one hands width space between the end of the mattress and the foot board was noted.

These observations led to the inspection into the home's bed system evaluations.

The Director of Nursing Operations (DNO) indicated that in 2012, the home undertook a least restraint policy review that included the sourcing of new beds and removal of the bed rails from the bottom of residents' beds in order to reduce the number of potential zones of entrapment. The standard was that all beds would have two half-length bed rails at the head of the bed and any new beds purchased would be Joerns brand.

According to the Director of Support Services (DSS), since 2014, forty one Joerns beds have been purchased. The DSS indicated that three different types of beds are used in the home: Joerns, Stryker and Bertec, and that the half-length bed rails used are the make and model original to the bed system. In total, the home has 450 beds that each have half –length bed rails.
The health care records of resident #013, #001, #041, #008, #014, #004 and #040 were reviewed. The use of bed rails was located in the MDS and/or the written plan of care. No assessments related to the use of bed rails for these seven residents were located.

RNs #134 and #123 indicated that the standard was to have two partial bed rails at the head of the bed for all residents, and that no further assessment related to the use of bed rails was completed unless the full bed rails were being considered. (551)

2. Further, the document, "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" is expected to be used as best practice to prevent resident entrapment when bedrails are used.

Again, as indicated previously, the DNO indicated that in 2012, the home undertook a least restraint policy review that included the sourcing of new beds and removal of the bed rails from the bottom of residents' beds in order to reduce the number of potential zones of entrapment. The standard was that all beds would have two half-length bed rails at the head of the bed and any new beds purchased would be Joerns brand.

According to the DSS, since 2014, forty one Joerns beds have been purchased. The DSS indicated that three different types of beds are used in the home: Joerns, Stryker and Bertec, and that the half-length bed rails used are the make and model original to the bed system. In total, the home has 450 beds that each have half –length bed rails.

The home was unable to produce any record to indicate that any of the bed systems had been evaluated since 2012 such as when a new resident was admitted to the home or when a component of the resident's bed system was modified.

According to OT #135, many residents in the home have therapeutic mattresses on their beds and while it is the OT's responsibility to assess the resident for a non-standard mattress, no further formal bed system evaluation, including potential zones of entrapment, is conducted. A list provided by the Director of Community Outreach and Programming which includes the OT department indicated that eighty residents were using therapeutic mattresses.

On April 3, 2017, the DNO indicated that staff would initiate an assessment to evaluate why the resident was using the bed rails, the risks associated with the use of bed rails and would assess the bed system for zones of entrapment, as no current resident assessment with regards to the use of bed rails and bed system evaluation existed.

The severity of harm related to resident's bed assessment and risk of potential zone of entrapment was determined to be "potential for actual harm". The scope was identified as "widespread" as the residents using bed rails were not assessed, neither was the bed systems evaluated and steps were not taken into consideration to prevent resident entrapment. (551)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 07, 2017

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

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 13th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PAULA MACDONALD

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