Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 30, 2020	2020_643111_0011	009688-20	Complaint

Licensee/Titulaire de permis

Medlaw Corporation Limited
42 Elgin Street Thornhill ON L3T 1W4

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

Pinecrest Nursing Home (Bobcaygeon)
3418 County Road 36, R.R. #2 BOBCAYGEON ON K0M 1A0

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

LYNDA BROWN (111), BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 8 to 11, 2020.

A complaint inspection (Log #009688-20) was completed related infection control program, environmental concerns and safe and secure home.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Licensee, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activity Coordinator, Housekeepers (HSK), Physiotherapy Assistant (PTA) and residents.

During the course of the inspection, the inspectors observed: staff infection prevention and control (IPAC) practices, housekeeping practices, physical distancing practices, resident bed systems, housekeeping cleaning schedules, housekeeping staff work schedules, IPAC audits, bed safety audits and observed bed rails. The following policies and procedures were also reviewed: IPAC policies and procedures, housekeeping policy and procedures, bed maintenance policy and procedure, bed rail and entrapment policy and procedure.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **2 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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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 :

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

Prevailing practices with respect to bed rail use were identified by the Director of the Ministry of Long-Term Care in August 2012 and again in March 2019. The latter notice was posted on the Long-Term Care Homes (LTCH) web portal for access by all Administrators and cited both the guideline developed by Health Canada entitled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008, and a companion guide entitled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration). These documents provide the necessary guidance in establishing a clinical assessment where bed rails are used and is expected to be used as the best practice document in LTCHs.

According to the Clinical Guidance document, “in creating a safe bed environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape”. Other guiding principles include:

•Evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual resident.
•Decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized resident assessment using an interdisciplinary team with input from the resident, family or the resident’s substitute decision maker.

•The resident's right to participate in care planning and make choices should be balanced with the caregivers' responsibility to provide care according to an individual assessment, professional standards of care, and any applicable acts and regulations.

Policy considerations include:

•The formation of an interdisciplinary team that includes, but is not limited to: personal support workers, nursing, social services, and dietary personnel; physicians; rehabilitation and occupational therapists; resident; family (or substitute decision maker); and medical equipment (bed system) suppliers.
• Prior to the application of any bed rail, an initial assessment of the resident upon admission to determine whether the resident has a history of bed rail use and bed related injuries, mobility, medication use, pain, incontinence, risk of falls, cognition, medical condition, communication deficits, physical limitations, sleep habits, behaviours or other factors that may affect the safe use of bed rails, should they be suitable for the resident.
•A sleep assessment is conducted before bed rails are applied to determine if the resident has any conditions that may affect their safety while in bed and impacts their ability to sleep, such as any sleep disorders, sleep habits, comfort, bed suitability and safety, behaviours and individual needs.
•If bed rails are identified by the interdisciplinary team as a benefit to the resident, to improve bed mobility and/or transfers, bed rail alternatives and care interventions are trialled first. All attempts to use the alternatives and/or interventions are documented. If not successful, the team formulates a clear, comprehensive and documented conclusion as to the risks versus benefits that identifies why other care interventions were not appropriate or not effective. Once bed rails are applied, on-going monitoring is conducted by personal support workers and nursing staff for risks and hazards associated with bed rail use.
•Bed rail use for resident bed mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan.

The Director of Care (DOC) acknowledged that they did not review the Clinical Guidance document and did not reference the Guide in their "Resident Safety: Bed Rails and Bed Entrapment" policy revised on January 25, 2019. The policy was limited in scope and failed to include several principles and policy considerations identified in the Clinical Guide. The licensee's "Bed rail Assessment VI" form was also reviewed. During the inspection, three residents were observed and the following noted;

A) The overall resident assessment process did not include any documentation related to a sleep assessment, either before or after bed rails were applied. There were no details as to how this process would be conducted in the policy and no questions were included on the bed rail assessment form as to who would monitor the residents, for how long and at what frequency, the specific hazards or risks that would need to be monitored while the resident is in bed with one or more bed rails applied, how to mitigate the specific hazards and what alternatives to bed rails are available and trialled before the application of bed rails. The bed rail assessment form included some questions related to different types of risks such as risk of climbing over, around or between the bed rails, confusion, agitation, disorientation, delirium and uncontrolled movements. It was not clear if staff answering the question regarding the risk of climbing over, around or between the bed rail would know the answer if the resident was not observed while sleeping over several nights. The policy identified that the resident was to be assessed within 24 hours of admission and did not direct anyone to actually monitor the resident while in bed for risks.

Residents #012 and #013 were both provided with a bed system that failed entrapment in and around their specified bed rails. Both residents had two or more behavioural risks which increased their likelihood of entrapment, suspension or injury. Neither resident had any information in their bed rail assessment that indicated that their bed rails did not pass entrapment and whether they had a sleep assessment completed which determined their overall risk for having bed rails applied based on their behavioural risks and medical condition (risk versus benefit conclusion).

B) The bed rail assessment form included some care interventions but did not identify what alternatives to bed rails were trialled to minimize or eliminate the risks of strangulation, suspension, entrapment, entanglement, injuries, skin tears or bruising. The bed rail assessment form included a number of interventions, which are applicable whether a bed rail was applied or not.

Residents #011, #012 and #013 did not have any information identified in the bed rail assessment identifying what specific alternatives were trialled prior to the application of bed rails. Care interventions were identified for all three, but there was no information as to whether the interventions were successful or not before bed rails were applied.

C) The bed rail assessment form did not include questions related to any sleep assessment outcomes, falls history from bed, bed mobility or bed transfer status. These questions would assist the assessor in determining if the resident would benefit from a

bed rail for bed mobility and transfers based on their status to use the bed rails for this purpose. Bed rails of any size are not a falls prevention device and increase the risk of a resident climbing over bed rails or getting lodged or entrapped by the bed rail as they attempted to roll off the bed. A section of the form was included that required the assessor to check off reasons for bed rail use and they included; staff, family/POA or resident expressed the need for bed rails, followed by whether the bed rail was considered a restraint or not. There were no risk over benefit questions requiring the assessor to document whether the interdisciplinary team deemed the bed rails to be of greater risk than if no bed rails were applied.

Resident #012 was identified to have specified responsive behaviours and cognitively impaired. No information was included in the bed rail assessment about the resident's history of falls and whether they were from bed and whether a different bed system was trialled, whether specified falls prevention interventions were trialled or a different type of mattress. The POA and staff decided that the resident required specified bed rails to prevent falls from bed. No other information was included to establish the level of risk the resident had with or without bed rails. The resident was observed to be in bed on a specified date and was provided with a bed that could not be lowered to the floor.

D) The bed rail assessment form did not specify what interdisciplinary staff members participated in the evaluation of the residents. The assessment forms reviewed did not have any names listed on the form. According to the licensee's bed rail policy, the RN conducts the resident assessment upon admission and the decision to use bed rails was a multidisciplinary decision based on information received from the resident or their power of attorney and a person from the Local Health Integrated Network (LHIN). No other key individuals were listed, especially those that provide direct care to the resident.

E) The most recent care plan for residents #011 and #013 did not include any direction for staff about the residents bed rail use, reasons for use, when bed rails were to be applied or how many and type of bed rails to be used. Both bed rail assessment forms included a check box that required the assessor to tick off whether the plan of care was updated. Both were checked off with a "yes". The licensee's policy included the requirement for the registered nurse to identify the reason for bed rail use and whether a restraint or not was to be included in the resident's plan of care.

The DOC identified that they felt pressured by the residents or their substitute decision maker to allow bed rails to remain on resident beds, despite the risks associated with certain bed rail types. The DOC stated the risks were explained to families or residents

and they verbally consented to having the bed rails in place. As such, the licensee followed the direction received by certain individuals as opposed to the interdisciplinary team into their practices without balancing their obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by s. 15(1)(a) of O. Regulation 79/10.

The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with the identified prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The long-term care home was equipped with approximately 31 bed systems that were verified by the owner of the home to have been purchased approximately 40 years ago. Most of these beds had two three-quarter length chrome bed rails attached to the frames. When in the raised position, the bed rails were loose by design. The tops of the bed rails could easily be nudged away from the edge of the mattress by approximately three inches while the bottom of the bed rail stayed in place, creating a "V" shape. The bed rails were not stable and could not be relied upon for stability.

The lowest horizontal bar within the rail frame curved upwards, creating an opening large enough for a small adult head. When the bed was flat, the opening was not a concern as it was below the top level of the mattress. However, when the head of the bed was raised to a sitting position, the top of the mattress dropped to align with the opening in the bed rail. Resident’s who are not able to maintain a seated position and move around on the bed may entrap a limb or their head within this opening.

According to the DOC, who evaluated the beds with the required tool used to measure entrapment zones, the area where the lowest horizontal bar curved upwards failed two separate zones of entrapment when the head of the bed was articulated upwards. All other areas of the bed passed entrapment. However, the DOC did not have any documentation of the bed system evaluation she completed, identifying the dates of the evaluation, the specific bed (with serial number or identifier), the specific mattress (with identifier) and the specific zones of entrapment (1 through 4) that were measured and either failed or passed entrapment.

The DOC reported that they tried to determine if another bed rail style could be added to

the frame, but no other rails would fit to the existing holes on the bed frame from other bed manufacturers. Some bed rails were removed where residents and or their substitute decision makers (SDM) consented to their removal. Otherwise, if they did not, no other actions were taken to deal with the failed zones, whether to remove the bed rails entirely without resident or SDM consent or determine if an accessory would suitably seal the gap. Residents who used the bed rails were informed that the bed rails were a safety risk and if they agreed, they were permitted to use them at their own risk.

Three beds (two unoccupied and one occupied by residents) were observed with a portable bed rail on one side of the bed. All three were different and were not manufactured for the specific bed systems they were observed on. Portable bed rails are sold in retail stores for the purposes of domestic home use and are not permitted on adult hospital beds. The DOC felt that these portable bed rails, which were designed to slide under the mattress, were a suitable alternative for residents who could get out of bed independently. The home did not have enough bed systems with quarter bed rail options for all residents who chose to use a rail to transfer themselves in and out of bed. The DOC was not aware that the portable bed rails failed entrapment zone one, which is the space between the frames on either side of the portable rail. The DOC was unaware of how a resident may become entrapped on a portable rail until informed.

The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Additional Required Actions:

CO # - 002 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. 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).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

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

A complaint was received regarding concerns with the home's infection, prevention and control (IPAC) practices.

During observations by Inspector #111 and #120 from specified dates, at various times, the Inspectors observed ongoing practices where staff were not participating in the implementation of the IPAC program. The home had a number of residents on droplet/contact precautions (in a number of resident rooms) at the time of the inspection.

The following IPAC concerns were observed/identified:

A. Physical distancing: on a specified date, two staff were observed sitting outside the home under a gazebo, within two feet of one another and not maintaining the required 6-foot distance from each other or wearing masks. Later the same day, two staff were observed sitting in a car together in the parking lot, both in the front seat and not physical

distancing or wearing a mask. Resident #012 and #013 were observed sitting in the lounge in their wheelchairs, within three feet of each other and neither resident was wearing a mask.

B. Screening: Upon entry to the home, the staff member screening visitors was screening the Inspectors while wearing a mask and no protective eye wear. On a different date, a different entrance screener was observed screening staff that were exiting the home and was not wearing any eye protection.

C. Hand Hygiene: PSW #101 was observed wearing the same pair of gloves throughout the home, entering and exiting resident rooms without performing hand hygiene/or changing their gloves. Housekeepers #109 and #110 were observed by inspector #120 wearing gloves in the corridor while pushing their housekeeping carts. Housekeeper #109 was observed wearing gloves while mopping the corridor. The gloves were not required for these duties. PSW #114 was observed portering residents from the dining room to the hallway wearing the same pair of gloves. The same PSW was observed entering/exiting resident rooms, while wearing the same pair of gloves and no hand hygiene was completed.

D. Donning/doffing of PPE: PTA #103, PSW #106 and #115 were observed improperly donning/doffing PPE (not donning/doffing in the correct order) upon entry/exit to a resident's room (on contact/droplet precautions) and improperly tying the gown (only tying the top). The PTA was also observed placing their laptop on the floor in the same resident's room, then doff their PPE and re-entered the room to collect their lap top. PSW #113 was observed entering another resident's room (on droplet/contact precautions) without correctly donning their gown (only fastened at the neck) which allowed the gown to gather in front of the staff member. The same PSW was also observed then providing care to a second resident in the same room while wearing the same PPE. The PSW doffed their PPE and then donned new PPE to enter another resident's room (on droplet/ contact precautions), but had their eye protective gear sitting on the top of their head when they entered the room. A member of the management team was observed walking throughout the home, frequently touching the front of their mask and was observed moving their mask down from their nose while talking to staff member at the nursing station. PSW #115 was observed walking down the hallway wearing a mask and eye protection, then return back down the hallway to access the PPE station and don a gown and gloves and then enter a resident's room (on droplet/contact precautions). PTA #103 was observed exiting a resident's room (on droplet/contact precautions) and crossed the hallway to access a hand sanitizer bottle, as there was no hand sanitizer available

outside of the resident's room. The PTA later exited the same resident's room, while still wearing their PPE, walked down the hallway a few rooms away to access antimicrobial wipes (Virox) and then re-entered the resident's room on isolation to wipe down their equipment. PSW #104 was observed serving a drink and speaking with resident #005 (on droplet/contact precautions) at the doorway and wearing only a mask (no eye protective wear).

E.Cleaning: Disinfectant wipes were not made conveniently available in resident washrooms or bedrooms for cleaning and disinfection of devices such as wash basins, physio equipment or laptops, thereby necessitating a PSW and/or PTA to take additional steps to perform a simple duty. PSW #104 was observed by inspector #120 disposing bath water from a basin in a resident's washroom sink and left the residents room with the same gloves on. Inspector #111 observed the same PSW enter the hall and pull out a disinfectant wipe from a plastic container and walk back into the room. Inspector #120 then observed the PSW use the wipe to clean the wash basin. The PSW contaminated the disinfectant wipe container with their gloves which should have been removed and hand hygiene conducted before they left the room. PSW #104 was then observed by Inspector #111 wearing gloves throughout the hallway, then entered a resident's room, without removing their gloves or completing hand hygiene.

F. Cohorting: PSW #113 reported resident #001 was on contact/droplet precautions after returning from the hospital and was placed in a room with resident #002. There were a number of empty rooms available.

G. PPE stations: Observations of the PPE stations in both the north and south wing indicated they were placed at the beginning and end of each hallway. The PPE stations did not all consistently have the required supplies (i.e. some stations only had large gowns), donning/doffing signage and discard bins were set up outside of specified resident rooms that were not on isolation. A number of identified resident rooms had residents on isolation for droplet/contact precaution, but no PPE stations at the entrance to those rooms.

H. Housekeeping: During the inspection, Inspector #120 observed that two housekeepers were scheduled to work each day and two were observed cleaning resident bedrooms, dining room and activity room, but not the tub rooms or staff room. The Administrator was requested to provide the current daily cleaning schedule. The schedule did not include cleaning and disinfection of surfaces in their high traffic areas such as the tub/shower room, staff lunch room, locker room and washroom and

boardroom (used by many staff). The Administrator reported that the schedule was temporary until they had time to amend and re-organize the housekeeping routines and schedules.

2. The following policies, practices or procedures were also noted to not follow best-practice guidelines:

Related to Hand Hygiene:
The Provincial Infectious Disease Advisory Committee on Infection Control (PIDAC-IP) produces best-practice knowledge products that are evidenced-based. As per the PIDAC "Routine Practices and Additional Precautions to All Health Care Settings", 3rd edition (dated September 2012), specific to hand hygiene and co-horting:
-On page 5, hand hygiene is to be performed with an alcohol-based hand rub (ABHR) or with soap and water before and after contact with a resident or their environments.
-On page 6, control of the environment, appropriate placement and bed spacing such as a single room and private toileting facilities for residents.
-On page 10, staff may be less likely to wash their hands when wearing gloves for routine tasks. The process of PPE removal requires strict adherence to a formal protocol to prevent contamination.
-On page 68: wear gloves for direct care, wearing gloves is not a substitute for hand hygiene, remove gloves on leaving the room or bed space and perform hand hygiene.

Related to Access to PPE:
Review of the licensee's IPAC policy, under infection control stations, the policy indicated that infection control stations were to be provided in the north and south wings to provide a convenient source of IPAC supplies. Each wing was to have six drawer chests to hold supplies. Additional supplies could be found on the linen carts in each hall. The infection control stations were to be near the soiled utility rooms and at the far end of each hall.

The Provincial Infectious Disease Advisory Committee on Infection Control (PIDAC-IP) produces best-practice knowledge products that are evidenced-based. As per the PIDAC "Routine Practices and Additional Precautions to All Health Care Settings", 3rd edition (dated September 2012) which indicated under personal protective equipment (PPE): on page 10, PPE should be put on just prior to the interaction with the resident. When the interaction for which PPE was used has ended, PPE should be removed immediately and disposed of in the appropriate receptacle. On page 11, health care settings must ensure that staff have sufficient supply of and quick, easy access to the PPE required.

During an interview with the PTA, PSW #113 and #106 by Inspector #111, they indicated they were required to travel down the hall from a resident room on contact/droplet precautions due to the location of PPE stations being placed at the end of each hallway or because the PPE stations did not contain all the required PPE.

Staff having to travel four to five rooms to access PPE or to doff PPE can pose a risk of cross contamination. Each PPE station also did not have a sufficient supply or easy access to the PPE or disinfecting wipes. Some of the stations only had large isolation gowns, which smaller staff were having to travel back and forth down each hallway to find a suitable gown size or to access the sanitizing wipes.

Related to Surveillance:
Review of the licensee's Infection Prevention and Control (IPAC) policy (reviewed July 2019), entitled Procedure for Managing Outbreaks,"early recognition of a potential problem will be aided via the use of the 24 hours report book, use of the short-term illness monitoring sheet and progress notes. The DOC or designate is to notify the Medical Advisor physician and Health Unit of clustering of cases". This policy did not include the use of Appendix 3, as per the guideline from the MOHLTC for Respiratory Outbreak Line Listing Form.

Review of the Recommendations for the Control of Respiratory Infection Outbreaks in Long Term Care Homes, by the Ministry of Health and Long-Term Care (MOHLTC) (March 2018), indicated under 2.2.3, Methods of Data Collection for Surveillance: "Daily surveillance is the most effective way to detect respiratory infections. Residents with respiratory and other symptoms should be noted on the daily surveillance form (refer to Appendix 3 - Sample Respiratory Outbreak Line Listing Form). This form should be easy to use and include patient identification and location, date of onset, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form should be forwarded to the Infection Control Practitioner (ICP) on a daily basis and any suspected outbreak should be reported immediately to the ICP".

The line listing form identified by MOHLTC was not included in their policy as per best practice, for early recognition of a potential outbreak and the form was not forwarded to the ICP on a daily basis for a suspected outbreak.

Related to monitoring of IPAC practices:
According to the PIDAC guideline, "Best Practices for Hand Hygiene in All Health Care Settings, 4th edition", April 2014, 1. Recommendations on page 9, A multidisciplinary,

multifaceted hand hygiene program must be developed and implemented in all health care settings, including hand hygiene agents that are available at point-of-care in all health care settings. The hand hygiene program must also include: d) ongoing monitoring and observation of hand hygiene practices, with feedback to health care providers

During an interview with the DOC and RN #100, they indicated the only monitoring of IPAC practices in the home for 2020 was an observation tool for long-term care (to assess hand hygiene practices) and a PPE compliance audit. They both confirmed the only audit completed was on a specified date.

Review of the observation tool for long-term care completed on the specified date, indicated a number of staff were observed for hand hygiene practices but did not indicate which staff members. The PPE compliance audit indicated one staff member was observed for donning/doffing practices and did not indicate which staff member was observed. This audit confirmed the staff member failed to properly doff their mask and eye protective wear.

The DOC confirmed the IPAC policy did not reflect best practice for daily monitoring of infections in the home and the policy did not provide clear direction on which monitoring tools were to be used or when, for monitoring of IPAC practices in the home.

Related to Housekeeping practices during an Outbreak:
Inspector #120 reviewed the licensee's housekeeping policies and procedures (revised in February 2019) and indicated that for resident room isolation cleaning, cleaning during outbreaks and routine daily cleaning were all based on the availability of two housekeepers. Outlined in their policy entitled "Daily Routine during an Outbreak" the "centre core housekeeper" was tasked to clean high touch surfaces, common washrooms and the nursing station twice during their shift while the "resident wing housekeeper" would complete the discharge (for those who came out of isolation) cleaning and their regular cleaning routine.

According to housekeeping staff schedules during specified dates, three housekeepers were available. However, only one housekeeper (#110) worked on specified dates and no indication that any housekeeper worked on specified dates. During the specified dates, two housekeepers each had a number of days vacations and one became ill for a number of days upon their return. Housekeeper #110 was shown the March housekeeping schedule and they confirmed that they worked alone during many of the days in March 2020, and could not complete the expected cleaning and disinfection

duties.

According to evidence-based practices related to infection prevention and control, entitled “Best Practices for Environmental Cleaning for Infection Prevention and Control, April 2018” and “Routine Practices and Additional Precautions in all Health Care Settings, 2012”, routine cleaning and disinfection of the health care environment is an essential component of and infection prevention and control program and is a measure that reduces the risk of transmission of harmful microorganisms. During an outbreak of an infectious disease or high-demand periods, sufficient staffing and resources to allow for additional cleaning and disinfection that does not compromise routine cleaning is necessary.

The licensee did not ensure that adequate housekeeping staff were available in the home to complete the required cleaning and disinfection of environmental surfaces before and during their outbreak. A respiratory outbreak was declared by local public health officials during a specified period. Respiratory symptoms were recorded by registered staff for residents beginning on a specified date.

During an interview with the Administrator by Inspector #120, they confirmed that they were also the Environmental Services Supervisor, managed the housekeepers and that they have always had just two housekeepers. During the outbreak, the Administrator identified that the extent and seriousness of the outbreak was not anticipated, the situation became overwhelming and many of the health care and environmental services staff became ill and there was no back up staff available to call upon. The Administrator stated that on some days they had only one housekeeper until external services were able to offer assistance.

During separate Interviews with RN #100 (IPC) and the DOC, by Inspector #111, both confirmed that staff and residents were to be physically distancing six feet apart or wearing a mask both within and outside of the home, staff were to be performing hand hygiene and removing gloves, when entering and exiting resident rooms and following proper donning/doffing of PPE procedures. The DOC indicated no awareness of best practice guidelines related to where point-of-care for hand hygiene stations were to be located. The DOC also confirmed that resident #001, upon return from hospital on a specified date, was placed into a four-bed ward room with resident #002, despite the home having multiple empty rooms and should have been placed in a separate room. The DOC and RN #100, both indicated no awareness of current best-practice regarding placement of PPE stations and were following their policy. They both indicated that the

PPE stations were always kept at the beginning and the end of each wing, as well as in the middle of the hallway on the clean linen carts regardless if the home is in outbreak or not. They were not aware that there was no PPE station set up in the middle of the hall on clean linen carts. The DOC and RN #100 both confirmed they did not use the appendix 3 - Sample Respiratory Outbreak Line Listing Form for daily monitoring of infections and were not aware that this tool was to be used for daily surveillance of infections. RN #100 indicated they only utilized that tool on a monthly basis to track all infections in the home. The monthly tracking tool was not provided.

The infection prevention and control program is required to include measures to prevent the transmission of infections as per s.86(1)(b) under the LTCH Act. Measures to prevent the transmission of infections include but are not limited to hand hygiene, cleaning and disinfection, surveillance, appropriate donning and doffing of personal protective equipment (PPE), cohorting residents, proper glove use and physical distancing. The licensee failed to ensure that staff participated in implementing these measures to minimize or prevent the transmission of infections.

3. The licensee failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and staff on every shift record symptoms of infection in residents and take immediate action as required.

Review of the line listing from Public Health (PH) indicated the home was declared in respiratory outbreak on a specified date.

Review of the nursing shift report and the progress notes for the following residents (#001, #010, #015, #017, #018, #019, #020 and #023) during a specified period, indicated there were a number of residents that were exhibiting symptoms a number of days before they were placed in isolation and before the suspected outbreak was reported to the PH unit as follows:
- Resident #001 and #015 developed specified symptoms and were placed on isolation on a specified date. These two residents had their symptoms two days before the first resident (#017) was identified on the line listing for PH. These two residents were not identified on the line listing until a number of days later.
-There were two residents (#010 and #017) that had developed symptoms and were placed on isolation on the day the PH line listing only indicated one resident (#017) was noted to have symptoms. Resident #010 was not identified on the line listing until a number of days later. Resident #010 was tested and diagnosis confirmed.

- Resident #018 developed specified symptoms on a specified date and was not placed on the line listing.
- Resident #019, developed specified symptoms on a specified date and was not placed on isolation or added to the PH line listing until a number of days later.
- Resident #020 developed specified symptoms on a specified date but were not identified on the line listing until the following day. Resident #020, was admitted to the home on a specified date and developed their symptoms a number of days after their admission and was not placed on isolation until the following day. Two days later, the resident was tested and diagnosis confirmed.
- Resident #023 developed specified symptoms on a specified date but was not identified on the line listing until a week later.
- At the time when PH was notified of a suspected outbreak, a number of residents had already been on isolation or had symptoms of infection.

Review of the Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, by the Ministry of Health and Long-Term Care (MOHLTC) (March 2018), indicated under Methods of Data Collection for Surveillance: Daily surveillance is the most effective way to detect respiratory infections. Residents with respiratory and other symptoms should be noted on the daily surveillance form (refer to Appendix 3 - Respiratory Outbreak Line Listing Form). This form should be easy to use and include patient identification and location, date of onset, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form should be forwarded to the ICP on a daily basis and any suspected outbreak should be reported immediately to the ICP.

Review of the licensee's Infection Prevention and Control (IPAC) policy (reviewed July 2019), indicated under procedure for managing outbreaks, early recognition of a potential problem will be aided via the use of the 24 hours report book, use of the short-term illness monitoring sheet and progress notes. The DOC or designate was to notify the Medical Advisor physician and Health Unit of clustering of cases. This policy did not include the use of Appendix 3 (Respiratory Outbreak Line Listing Form), as per the guideline from the MOHLTC. The short-term illness form used by the home did not provide clear patient identification and location, date of onset, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form was not forwarded to the ICP nurse on a daily basis and a suspected outbreak was not reported immediately to the Medical Advisor, Health Unit or the ICP.

During an interview with the DOC by Inspector #111, they indicated they were the IPAC

nurse and was not in the home until the day before the outbreak was declared. The DOC confirmed that no short-term illness form was put in place until a number of days later, when the PH was notified of a suspected respiratory outbreak. The DOC indicated RN #100 was the Infection Control Practitioner (ICP) and the back up IPAC nurse, but any RN should have started their short-term illness form. The DOC indicated that resident #001 who exhibited symptoms on a specified date, was not added to the line list. The DOC indicated resident #015 who also exhibited symptoms on a specified date, was missed on the line list and not added until a number of days later. The DOC indicated resident #018 was never added to the line list as they felt their symptoms were unrelated. The DOC was not aware of the inconsistencies with the actual date of resident symptom onset and when the residents symptoms onset were actually recorded as starting on the line listing. The DOC was also not aware that specified residents who were exhibiting symptoms of infection, were also not immediately placed on isolation and should have been.

The licensee failed to ensure that the staff monitored and recorded symptoms of infection in residents on every shift in accordance with evidence-based practices and/or in accordance with prevailing practices (utilizing the respiratory outbreak line listing) and that staff took immediate actions as required as residents were not immediately placed on isolation, the ICP was not informed and the PH was not immediately notified of a suspected outbreak.

4. The licensee has failed to ensure that the information that was gathered on every shift about the residents' infections, was analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

During separate interviews conducted with RN #100, RN #117 and RPN #105 by Inspector #111, they indicated that the home’s prevailing practice of recording of symptoms on the nursing report shift, was to also be recording on the short-term illness monitoring record in order to be analyzed daily to detect the presence of infection. They all confirmed that no short-term illness report form was completed when residents were demonstrating signs of infection until six days later and they were unaware that this was not best-practice or the prevailing practice. RN #100 (ICP), indicated they used the infection tracking form on a monthly basis to detect trends of infections. Request for the monthly tracking forms for 2020 were not provided.

Review of the nursing shift reports and resident progress notes did not demonstrate how

the information that was gathered, was analyzed daily to detect the presence of infection and there was no indication of a monthly review to detect trends for the purpose of reducing the incident of infections and outbreaks.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The licensee failed to ensure that the resident-staff communication and response system was easily seen by residents, staff and visitors at all times.

During observations by Inspector #120 on specified dates, the activation station and call bell cord were observed to be hidden behind a large organ that was positioned against the wall in the activity room. The Administrator was shown the situation on a specified date. The Administrator pulled the called bell cord out from behind the organ and laid it on top of the organ, thinking that it would resolve the issue. The Administrator was informed that call bell string itself sitting on the organ would not suffice and that the entire activation station was to be visible so that people would know what the call bell string was for.

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 resident-staff communication and response system is easily seen by residents, staff and visitors at all times, to be implemented voluntarily.

WN #4: 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 :

The licensee failed to ensure that furnishings and equipment were maintained in a safe condition and in a good state of repair.

A complaint was received regarding concerns with the home's bed systems.

1. On a specified date, a tour of the resident bedrooms revealed a number of beds, with a hard piece of plastic attached on one side of the bed frame that had broken away. Each had jagged and sharp pieces of the plastic left on the frame that could have caused a skin tear or other injury. The plastic was noted on other beds to be in one piece with a slot cut out of it to allow a worker to insert their hand to guide them to a lever under the bed frame to adjust the head of the bed.

The DOC was immediately shown the broken plastic and was not aware of the condition. The DOC responded by having a maintenance person check all of the beds and remove any of the broken plastic. The following day, a random tour revealed that the broken plastic had been removed.

A review of the licensee's "MDPM Bed Safety Audit" check list for bed condition did not include these plastic pieces specifically on the list, however it did include a check for rough edges on bed frames. The Administrator/Environmental Services Supervisor was requested to provide the most recent inspection related to the condition of the beds. An audit was completed by a maintenance person on a specified date for all of the beds in the home with no "rough edge" issues. The licensee's policy and procedure entitled "MDPM Bed Safety" identified that the audit was to be completed quarterly.

2. An electric baseboard heater was observed in the tub/shower room on a specified date by Inspectors #120 and #111. The front cover was lying on the floor and the aluminium heating fins exposed, which were very sharp. Inspector #111 revisited the tub room a number of days later and noted the same condition. A review of the maintenance log from specified dates, did not include any notations from staff about the condition of the heater. The Administrator/Environmental Services Supervisor was not aware of the condition of the heater.

The licensee failed to ensure that furnishings and equipment were maintained in a safe condition and in a good state of repair.

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 furnishings and equipment are maintained in safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

A number of housekeeping carts, provided to housekeepers of the home were not all equipped with a lockable enclosure in which to keep hazardous cleaning products. One cart with an enclosure did not have a key to the compartment, according to housekeeper #110. The other two carts were of an open design. When carts were observed to be in use on specified dates, the housekeepers kept them in corridors while cleaning rooms, with all of the products fully accessible to residents.

On a specified date, a cart used by housekeeper #110 which was of an open design and left in the corridor, included the storage of a specified cleaning product that was observed in use on a specified date by housekeeper #109, to clean the toilet bowl in it's undiluted state. The label included a symbol of a red diamond with an exclamation point inside of it. A review of the material data sheet for this product revealed that it can cause serious eye damage or irritation in it's undiluted state.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Issued on this 30th day of June, 2020

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

Original report signed by the inspector.

Ontario

Ministry of 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

Ministère des Soins de longue durée

Order(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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2020_643111_0011
Log No. / Registre no:	009688-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 30, 2020
Licensee / Titulaire de permis :	Medlaw Corporation Limited 42 Elgin Street, Thornhill, ON, L3T-1W4
LTC Home / Foyer de SLD :	Pinecrest Nursing Home (Bobcaygeon) 3418 County Road 36, R.R. #2, BOBCAYGEON, ON, K0M-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mary Carr

To Medlaw Corporation Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall comply with O.Reg. 79/10, s.220(4), by ensuring that staff participate in the implementation of the infection prevention and control program.

Specifically, the licensee shall:

1. Review and revise the existing IPAC policies to ensure they meet best-practice guidelines (as per PIDAC and Ministry guidelines) related to surveillance, monitoring of IPAC practices in the home, access to PPE and hand sanitizer and cohorting of residents.

2. Retrain all staff on proper hand hygiene practices, donning and doffing of PPE, visitor screening PPE requirements, surveillance, physical distancing requirements of residents and staff, self isolation practices for any residents newly admitted or returning from hospital and proper placement of PPE stations. A documented record is to be kept of the training of all staff.

3. Develop and implement a monitoring process to ensure compliance of all staff with the IPAC program, including practices of proper hand hygiene, physical distancing of residents and staff, both inside and outside of the home, screening of visitors and proper donning/doffing of PPE.

Grounds / Motifs :

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

A complaint was received regarding concerns with the home's infection, prevention and control (IPAC) practices.

During observations by Inspector #111 and #120 from specified dates, at various times, the Inspectors observed ongoing practices where staff were not participating in the implementation of the IPAC program. The home had a number of residents on droplet/contact precautions (in a number of resident rooms) at the time of the inspection.

The following IPAC concerns were observed/identified:

A. Physical distancing: on a specified date, two staff were observed sitting outside the home under a gazebo, within two feet of one another and not maintaining the required 6-foot distance from each other or wearing masks. Later the same day, two staff were observed sitting in a car together in the parking lot, both in the front seat and not physical distancing or wearing a mask. Resident #012 and #013 were observed sitting in the lounge in their wheelchairs, within three feet of each other and neither resident was wearing a mask.

B. Screening: Upon entry to the home, the staff member screening visitors was screening the Inspectors while wearing a mask and no protective eye wear. On a different date, a different entrance screener was observed screening staff that were exiting the home and was not wearing any eye protection.

C. Hand Hygiene: PSW #101 was observed wearing the same pair of gloves throughout the home, entering and exiting resident rooms without performing hand hygiene/or changing their gloves. Housekeepers #109 and #110 were observed by inspector #120 wearing gloves in the corridor while pushing their housekeeping carts. Housekeeper #109 was observed wearing gloves while mopping the corridor. The gloves were not required for these duties. PSW #114 was observed portering residents from the dining room to the hallway wearing the same pair of gloves. The same PSW was observed entering/exiting resident rooms, while wearing the same pair of gloves and no hand hygiene was completed.

D. Donning/doffing of PPE: PTA #103, PSW #106 and #115 were observed improperly donning/doffing PPE (not donning/doffing in the correct order) upon entry/exit to a resident's room (on contact/droplet precautions) and improperly tying the gown (only tying the top). The PTA was also observed placing their laptop on the floor in the same resident's room, then doff their PPE and re-

entered the room to collect their lap top. PSW #113 was observed entering another resident's room (on droplet/contact precautions) without correctly donning their gown (only fastened at the neck) which allowed the gown to gather in front of the staff member. The same PSW was also observed then providing care to a second resident in the same room while wearing the same PPE. The PSW doffed their PPE and then donned new PPE to enter another resident's room (on droplet/ contact precautions), but had their eye protective gear sitting on the top of their head when they entered the room. A member of the management team was observed walking throughout the home, frequently touching the front of their mask and was observed moving their mask down from their nose while talking to staff member at the nursing station. PSW #115 was observed walking down the hallway wearing a mask and eye protection, then return back down the hallway to access the PPE station and don a gown and gloves and then enter a resident's room (on droplet/contact precautions). PTA #103 was observed exiting a resident's room (on droplet/contact precautions) and crossed the hallway to access a hand sanitizer bottle, as there was no hand sanitizer available outside of the resident's room. The PTA later exited the same resident's room, while still wearing their PPE, walked down the hallway a few rooms away to access antimicrobial wipes (Virox) and then re-entered the resident's room on isolation to wipe down their equipment. PSW #104 was observed serving a drink and speaking with resident #005 (on droplet/contact precautions) at the doorway and wearing only a mask (no eye protective wear).

E.Cleaning: Disinfectant wipes were not made conveniently available in resident washrooms or bedrooms for cleaning and disinfection of devices such as wash basins, physio equipment or laptops, thereby necessitating a PSW and/or PTA to take additional steps to perform a simple duty. PSW #104 was observed by inspector #120 disposing bath water from a basin in a resident’s washroom sink and left the residents room with the same gloves on. Inspector #111 observed the same PSW enter the hall and pull out a disinfectant wipe from a plastic container and walk back into the room. Inspector #120 then observed the PSW use the wipe to clean the wash basin. The PSW contaminated the disinfectant wipe container with their gloves which should have been removed and hand hygiene conducted before they left the room. PSW #104 was then observed by Inspector #111 wearing gloves throughout the hallway, then entered a resident's room, without removing their gloves or completing hand hygiene.

F. Cohorting: PSW #113 reported resident #001 was on contact/droplet precautions after returning from the hospital and was placed in a room with

resident #002. There were a number of empty rooms available.

G. PPE stations: Observations of the PPE stations in both the north and south wing indicated they were placed at the beginning and end of each hallway. The PPE stations did not all consistently have the required supplies (i.e. some stations only had large gowns), donning/doffing signage and discard bins were set up outside of specified resident rooms that were not on isolation. A number of identified resident rooms had residents on isolation for droplet/contact precaution, but no PPE stations at the entrance to those rooms.

H. Housekeeping: During the inspection, Inspector #120 observed that two housekeepers were scheduled to work each day and two were observed cleaning resident bedrooms, dining room and activity room, but not the tub rooms or staff room. The Administrator was requested to provide the current daily cleaning schedule. The schedule did not include cleaning and disinfection of surfaces in their high traffic areas such as the tub/shower room, staff lunch room, locker room and washroom and boardroom (used by many staff). The Administrator reported that the schedule was temporary until they had time to amend and re-organize the housekeeping routines and schedules.

2. The following policies, practices or procedures were also noted to not follow best-practice guidelines:

Related to Hand Hygiene:
The Provincial Infectious Disease Advisory Committee on Infection Control (PIDAC-IP) produces best-practice knowledge products that are evidenced-based. As per the PIDAC “Routine Practices and Additional Precautions to All Health Care Settings”, 3rd edition (dated September 2012), specific to hand hygiene and co-horting:
-On page 5, hand hygiene is to be performed with an alcohol-based hand rub (ABHR) or with soap and water before and after contact with a resident or their environments.
-On page 6, control of the environment, appropriate placement and bed spacing such as a single room and private toileting facilities for residents.
-On page 10, staff may be less likely to wash their hands when wearing gloves for routine tasks. The process of PPE removal requires strict adherence to a formal protocol to prevent contamination.
-On page 68: wear gloves for direct care, wearing gloves is not a substitute for hand hygiene, remove gloves on leaving the room or bed space and perform

hand hygiene.

Related to Access to PPE:
Review of the licensee's IPAC policy, under infection control stations, the policy indicated that infection control stations were to be provided in the north and south wings to provide a convenient source of IPAC supplies. Each wing was to have six drawer chests to hold supplies. Additional supplies could be found on the linen carts in each hall. The infection control stations were to be near the soiled utility rooms and at the far end of each hall.

The Provincial Infectious Disease Advisory Committee on Infection Control (PIDAC-IP) produces best-practice knowledge products that are evidenced-based. As per the PIDAC "Routine Practices and Additional Precautions to All Health Care Settings", 3rd edition (dated September 2012) which indicated under personal protective equipment (PPE): on page 10, PPE should be put on just prior to the interaction with the resident. When the interaction for which PPE was used has ended, PPE should be removed immediately and disposed of in the appropriate receptacle. On page 11, health care settings must ensure that staff have sufficient supply of and quick, easy access to the PPE required.

During an interview with the PTA, PSW #113 and #106 by Inspector #111, they indicated they were required to travel down the hall from a resident room on contact/droplet precautions due to the location of PPE stations being placed at the end of each hallway or because the PPE stations did not contain all the required PPE.

Staff having to travel four to five rooms to access PPE or to doff PPE can pose a risk of cross contamination. Each PPE station also did not have a sufficient supply or easy access to the PPE or disinfecting wipes. Some of the stations only had large isolation gowns, which smaller staff were having to travel back and forth down each hallway to find a suitable gown size or to access the sanitizing wipes.

Related to Surveillance:
Review of the licensee's Infection Prevention and Control (IPAC) policy (reviewed July 2019), entitled Procedure for Managing Outbreaks,"early recognition of a potential problem will be aided via the use of the 24 hours report book, use of the short-term illness monitoring sheet and progress notes. The DOC or designate is to notify the Medical Advisor physician and Health Unit of

clustering of cases". This policy did not include the use of Appendix 3, as per the guideline from the MOHLTC for Respiratory Outbreak Line Listing Form.

Review of the Recommendations for the Control of Respiratory Infection Outbreaks in Long Term Care Homes, by the Ministry of Health and Long-Term Care (MOHLTC) (March 2018), indicated under 2.2.3, Methods of Data Collection for Surveillance: "Daily surveillance is the most effective way to detect respiratory infections. Residents with respiratory and other symptoms should be noted on the daily surveillance form (refer to Appendix 3 - Sample Respiratory Outbreak Line Listing Form). This form should be easy to use and include patient identification and location, date of onset, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form should be forwarded to the Infection Control Practitioner (ICP) on a daily basis and any suspected outbreak should be reported immediately to the ICP".

The line listing form identified by MOHLTC was not included in their policy as per best practice, for early recognition of a potential outbreak and the form was not forwarded to the ICP on a daily basis for a suspected outbreak.

Related to monitoring of IPAC practices:
According to the PIDAC guideline, “Best Practices for Hand Hygiene in All Health Care Settings, 4th edition”, April 2014, 1. Recommendations on page 9, A multidisciplinary, multifaceted hand hygiene program must be developed and implemented in all health care settings, including hand hygiene agents that are available at point-of-care in all health care settings. The hand hygiene program must also include: d) ongoing monitoring and observation of hand hygiene practices, with feedback to health care providers

During an interview with the DOC and RN #100, they indicated the only monitoring of IPAC practices in the home for 2020 was an observation tool for long-term care (to assess hand hygiene practices) and a PPE compliance audit. They both confirmed the only audit completed was on a specified date.

Review of the observation tool for long-term care completed on the specified date, indicated a number of staff were observed for hand hygiene practices but did not indicate which staff members. The PPE compliance audit indicated one staff member was observed for donning/doffing practices and did not indicate which staff member was observed. This audit confirmed the staff member failed

to properly doff their mask and eye protective wear.

The DOC confirmed the IPAC policy did not reflect best practice for daily monitoring of infections in the home and the policy did not provide clear direction on which monitoring tools were to be used or when, for monitoring of IPAC practices in the home.

Related to Housekeeping practices during an Outbreak:
Inspector #120 reviewed the licensee's housekeeping policies and procedures (revised in February 2019) and indicated that for resident room isolation cleaning, cleaning during outbreaks and routine daily cleaning were all based on the availability of two housekeepers. Outlined in their policy entitled "Daily Routine during an Outbreak" the "centre core housekeeper" was tasked to clean high touch surfaces, common washrooms and the nursing station twice during their shift while the "resident wing housekeeper" would complete the discharge (for those who came out of isolation) cleaning and their regular cleaning routine.

According to housekeeping staff schedules during specified dates, three housekeepers were available. However, only one housekeeper (#110) worked on specified dates and no indication that any housekeeper worked on specified dates. During the specified dates, two housekeepers each had a number of days vacations and one became ill for a number of days upon their return. Housekeeper #110 was shown the March housekeeping schedule and they confirmed that they worked alone during many of the days in March 2020, and could not complete the expected cleaning and disinfection duties.

According to evidence-based practices related to infection prevention and control, entitled "Best Practices for Environmental Cleaning for Infection Prevention and Control, April 2018" and "Routine Practices and Additional Precautions in all Health Care Settings, 2012", routine cleaning and disinfection of the health care environment is an essential component of and infection prevention and control program and is a measure that reduces the risk of transmission of harmful microorganisms. During an outbreak of an infectious disease or high-demand periods, sufficient staffing and resources to allow for additional cleaning and disinfection that does not compromise routine cleaning is necessary.

The licensee did not ensure that adequate housekeeping staff were available in the home to complete the required cleaning and disinfection of environmental

surfaces before and during their outbreak. A respiratory outbreak was declared by local public health officials during a specified period. Respiratory symptoms were recorded by registered staff for residents beginning on a specified date.

During an interview with the Administrator by Inspector #120, they confirmed that they were also the Environmental Services Supervisor, managed the housekeepers and that they have always had just two housekeepers. During the outbreak, the Administrator identified that the extent and seriousness of the outbreak was not anticipated, the situation became overwhelming and many of the health care and environmental services staff became ill and there was no back up staff available to call upon. The Administrator stated that on some days they had only one housekeeper until external services were able to offer assistance.

During separate Interviews with RN #100 (IPC) and the DOC, by Inspector #111, both confirmed that staff and residents were to be physically distancing six feet apart or wearing a mask both within and outside of the home, staff were to be performing hand hygiene and removing gloves, when entering and exiting resident rooms and following proper donning/doffing of PPE procedures. The DOC indicated no awareness of best practice guidelines related to where point-of-care for hand hygiene stations were to be located. The DOC also confirmed that resident #001, upon return from hospital on a specified date, was placed into a four-bed ward room with resident #002, despite the home having multiple empty rooms and should have been placed in a separate room. The DOC and RN #100, both indicated no awareness of current best-practice regarding placement of PPE stations and were following their policy. They both indicated that the PPE stations were always kept at the beginning and the end of each wing, as well as in the middle of the hallway on the clean linen carts regardless if the home is in outbreak or not. They were not aware that there was no PPE station set up in the middle of the hall on clean linen carts. The DOC and RN #100 both confirmed they did not use the appendix 3 - Sample Respiratory Outbreak Line Listing Form for daily monitoring of infections and were not aware that this tool was to be used for daily surveillance of infections. RN #100 indicated they only utilized that tool on a monthly basis to track all infections in the home. The monthly tracking tool was not provided.

The infection prevention and control program is required to include measures to prevent the transmission of infections as per s.86(1)(b) under the LTCH Act. Measures to prevent the transmission of infections include but are not limited to

hand hygiene, cleaning and disinfection, surveillance, appropriate donning and doffing of personal protective equipment (PPE), cohorting residents, proper glove use and physical distancing. The licensee failed to ensure that staff participated in implementing these measures to minimize or prevent the transmission of infections.

3. The licensee failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and staff on every shift record symptoms of infection in residents and take immediate action as required.

Review of the line listing from Public Health (PH) indicated the home was declared in respiratory outbreak on a specified date.

Review of the nursing shift report and the progress notes for the following residents (#001, #010, #015, #017, #018, #019, #020 and #023) during a specified period, indicated there were a number of residents that were exhibiting symptoms a number of days before they were placed in isolation and before the suspected outbreak was reported to the PH unit as follows:
- Resident #001 and #015 developed specified symptoms and were placed on isolation on a specified date. These two residents had their symptoms two days before the first resident (#017) was identified on the line listing for PH. These two residents were not identified on the line listing until a number of days later.

-There were two residents (#010 and #017) that had developed symptoms and were placed on isolation on the day the PH line listing only indicated one resident (#017) was noted to have symptoms. Resident #010 was not identified on the line listing until a number of days later. Resident #010 was tested and diagnosis confirmed.
- Resident #018 developed specified symptoms on a specified date and was not placed on the line listing.
- Resident #019, developed specified symptoms on a specified date and was not placed on isolation or added to the PH line listing until a number of days later.
- Resident #020 developed specified symptoms on a specified date but were not identified on the line listing until the following day. Resident #020, was admitted to the home on a specified date and developed their symptoms a number of days after their admission and was not placed on isolation until the following day. Two days later, the resident was tested and diagnosis confirmed.

- Resident #023 developed specified symptoms on a specified date but was not identified on the line listing until a week later.
- At the time when PH was notified of a suspected outbreak, a number of residents had already been on isolation or had symptoms of infection.

Review of the Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, by the Ministry of Health and Long-Term Care (MOHLTC) (March 2018), indicated under Methods of Data Collection for Surveillance: Daily surveillance is the most effective way to detect respiratory infections. Residents with respiratory and other symptoms should be noted on the daily surveillance form (refer to Appendix 3 - Respiratory Outbreak Line Listing Form). This form should be easy to use and include patient identification and location, date of onset, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form should be forwarded to the ICP on a daily basis and any suspected outbreak should be reported immediately to the ICP.

Review of the licensee's Infection Prevention and Control (IPAC) policy (reviewed July 2019), indicated under procedure for managing outbreaks, early recognition of a potential problem will be aided via the use of the 24 hours report book, use of the short-term illness monitoring sheet and progress notes. The DOC or designate was to notify the Medical Advisor physician and Health Unit of clustering of cases. This policy did not include the use of Appendix 3 (Respiratory Outbreak Line Listing Form), as per the guideline from the MOHLTC. The short-term illness form used by the home did not provide clear patient identification and location, date of onset, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form was not forwarded to the ICP nurse on a daily basis and a suspected outbreak was not reported immediately to the Medical Advisor, Health Unit or the ICP.

During an interview with the DOC by Inspector #111, they indicated they were the IPAC nurse and was not in the home until the day before the outbreak was declared. The DOC confirmed that no short-term illness form was put in place until a number of days later, when the PH was notified of a suspected respiratory outbreak. The DOC indicated RN #100 was the Infection Control Practitioner (ICP) and the back up IPAC nurse, but any RN should have started their short-term illness form. The DOC indicated that resident #001 who exhibited symptoms on a specified date, was not added to the line list. The DOC indicated

resident #015 who also exhibited symptoms on a specified date, was missed on the line list and not added until a number of days later. The DOC indicated resident #018 was never added to the line list as they felt their symptoms were unrelated. The DOC was not aware of the inconsistencies with the actual date of resident symptom onset and when the residents symptoms onset were actually recorded as starting on the line listing. The DOC was also not aware that specified residents who were exhibiting symptoms of infection, were also not immediately placed on isolation and should have been.

The licensee failed to ensure that the staff monitored and recorded symptoms of infection in residents on every shift in accordance with evidence-based practices and/or in accordance with prevailing practices (utilizing the respiratory outbreak line listing) and that staff took immediate actions as required as residents were not immediately placed on isolation, the ICP was not informed and the PH was not immediately notified of a suspected outbreak.

4. The licensee has failed to ensure that the information that was gathered on every shift about the residents' infections, was analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

During separate interviews conducted with RN #100, RN #117 and RPN #105 by Inspector #111, they indicated that the home’s prevailing practice of recording of symptoms on the nursing report shift, was to also be recording on the short-term illness monitoring record in order to be analyzed daily to detect the presence of infection. They all confirmed that no short-term illness report form was completed when residents were demonstrating signs of infection until six days later and they were unaware that this was not best-practice or the prevailing practice. RN #100 (ICP), indicated they used the infection tracking form on a monthly basis to detect trends of infections. Request for the monthly tracking forms for 2020 were not provided.

Review of the nursing shift reports and resident progress notes did not demonstrate how the information that was gathered, was analyzed daily to detect the presence of infection and there was no indication of a monthly review to detect trends for the purpose of reducing the incident of infections and outbreaks.

The severity was a level 4 as immediate harm was identified. The scope was a

level 3, widespread as the infection prevention and control program affects all residents and staff. The compliance history was a level 3, as the home had non-compliance under the same subsection as follows: a Voluntary Plan of Correction (VPC) was issued to O.Reg. 79/10, s. 229(4) on May 16, 2018 during inspection #2018_716554_0007. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall comply with O.Reg.79/10, s. 15(1)(a) where 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 residents;(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment;

Specifically, the licensee shall complete the following:

1. Amend the home's existing policy entitled “Resident Safety: Bed Rails and Bed Entrapment” revised on January 25, 2019 to include guidance identified in the “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration) related to the following at a minimum;

a) the sleep assessment process (time frames for monitoring residents without bed rails, with bed rails, factors to consider); and
b) the alternatives available to bed rails; and
c) guidance for the assessors in being able to make clear decisions based on

the data acquired by the interdisciplinary team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
d) staff roles and responsibilities of each interdisciplinary team member who is involved in monitoring and assessing residents for risks related to the use of one or more bed rails; and
e) interventions or accessories that are available to mitigate any identified entrapment zones or risks related to any bed rail (as per the U.S. Food and Drug Administration's "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" June 21, 2006") and;
f) the role of the Substitute Decision Maker (SDM) and resident in selecting the appropriate device for bed mobility and transfers; and
g) the information required to be provided to residents and SDMs about bed rail use and when consent for use of bed rails is required; and
h) what types of bed system safety risks and maintenance issues need to be reported to maintenance; and
i) how registered staff are made aware of the bed entrapment status of each bed where bed rails would be applied.

2. Amend the home's existing "Bedrail Assessment VI" form to include;

a) the outcome of the resident's sleep assessment and what factors were considered during the assessment, and
b) the most appropriate alternative for the resident, including the option of mattresses with raised perimeter edges, soft rails (adjustable bolsters) or other products or accessories that were trialled prior to the application of one or more bed rails (where possible) and document when the alternative(s) was trialled, who monitored the alternative and if the alternative was effective during the specified trial time period; and
c) whether any entrapment risks were identified with the resident's bed system or risks associated with the resident's interaction with their bed system and if so, what accessories or other options were implemented and when, to reduce or eliminate the risks; and
d) the names of all staff who participated in the decision-making related to the resident and their bed rail use.

3. Re-assess all residents who currently have been provided with one or more bed rails in accordance with the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home

Care Settings, 2003" (developed by the US Food and Drug Administration).

4. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories or interventions that were required to mitigate any identified bed safety hazards, the type and size of the bed rail, why it is being used, when it is to be used, how many bed rails are to be applied and on what side of the bed.

5. All direct care staff are to be informed about the amended bed safety policy and provided with face to face education about bed entrapment zones, resident risk factors that are considered high risk for bed system injury or entrapment, the benefits versus the risks of bed rail use, alternatives to bed rail use, how to identify bed rails or other bed system components that are not safe or in good working order and who to report to and when.

Grounds / Motifs :

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

Prevailing practices with respect to bed rail use were identified by the Director of the Ministry of Long-Term Care in August 2012 and again in March 2019. The latter notice was posted on the Long-Term Care Homes (LTCH) web portal for access by all Administrators and cited both the guideline developed by Health Canada entitled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008, and a companion guide entitled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration). These documents provide the necessary guidance in establishing a clinical assessment where bed rails are used and is expected to be used as the best practice document in LTCHs.

According to the Clinical Guidance document, “in creating a safe bed environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape”. Other guiding principles include:

•Evaluation is needed to assess the relative risk of using the bed rail compared

with not using it for an individual resident.
•Decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized resident assessment using an interdisciplinary team with input from the resident, family or the resident's substitute decision maker.
•The resident's right to participate in care planning and make choices should be balanced with the caregivers' responsibility to provide care according to an individual assessment, professional standards of care, and any applicable acts and regulations.

Policy considerations include:

•The formation of an interdisciplinary team that includes, but is not limited to: personal support workers, nursing, social services, and dietary personnel; physicians; rehabilitation and occupational therapists; resident; family (or substitute decision maker); and medical equipment (bed system) suppliers.
• Prior to the application of any bed rail, an initial assessment of the resident upon admission to determine whether the resident has a history of bed rail use and bed related injuries, mobility, medication use, pain, incontinence, risk of falls, cognition, medical condition, communication deficits, physical limitations, sleep habits, behaviours or other factors that may affect the safe use of bed rails, should they be suitable for the resident.
•A sleep assessment is conducted before bed rails are applied to determine if the resident has any conditions that may affect their safety while in bed and impacts their ability to sleep, such as any sleep disorders, sleep habits, comfort, bed suitability and safety, behaviours and individual needs.
•If bed rails are identified by the interdisciplinary team as a benefit to the resident, to improve bed mobility and/or transfers, bed rail alternatives and care interventions are trialled first. All attempts to use the alternatives and/or interventions are documented. If not successful, the team formulates a clear, comprehensive and documented conclusion as to the risks versus benefits that identifies why other care interventions were not appropriate or not effective. Once bed rails are applied, on-going monitoring is conducted by personal support workers and nursing staff for risks and hazards associated with bed rail use.
•Bed rail use for resident bed mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan.

The Director of Care (DOC) acknowledged that they did not review the Clinical

Guidance document and did not reference the Guide in their “Resident Safety: Bed Rails and Bed Entrapment” policy revised on January 25, 2019. The policy was limited in scope and failed to include several principles and policy considerations identified in the Clinical Guide. The licensee’s “Bed rail Assessment VI” form was also reviewed. During the inspection, three residents were observed and the following noted;

A) The overall resident assessment process did not include any documentation related to a sleep assessment, either before or after bed rails were applied. There were no details as to how this process would be conducted in the policy and no questions were included on the bed rail assessment form as to who would monitor the residents, for how long and at what frequency, the specific hazards or risks that would need to be monitored while the resident is in bed with one or more bed rails applied, how to mitigate the specific hazards and what alternatives to bed rails are available and trialled before the application of bed rails. The bed rail assessment form included some questions related to different types of risks such as risk of climbing over, around or between the bed rails, confusion, agitation, disorientation, delirium and uncontrolled movements. It was not clear if staff answering the question regarding the risk of climbing over, around or between the bed rail would know the answer if the resident was not observed while sleeping over several nights. The policy identified that the resident was to be assessed within 24 hours of admission and did not direct anyone to actually monitor the resident while in bed for risks.

Residents #012 and #013 were both provided with a bed system that failed entrapment in and around their specified bed rails. Both residents had two or more behavioural risks which increased their likelihood of entrapment, suspension or injury. Neither resident had any information in their bed rail assessment that indicated that their bed rails did not pass entrapment and whether they had a sleep assessment completed which determined their overall risk for having bed rails applied based on their behavioural risks and medical condition (risk versus benefit conclusion).

B) The bed rail assessment form included some care interventions but did not identify what alternatives to bed rails were trialled to minimize or eliminate the risks of strangulation, suspension, entrapment, entanglement, injuries, skin tears or bruising. The bed rail assessment form included a number of interventions, which are applicable whether a bed rail was applied or not.

Residents #011, #012 and #013 did not have any information identified in the bed rail assessment identifying what specific alternatives were trialled prior to the application of bed rails. Care interventions were identified for all three, but there was no information as to whether the interventions were successful or not before bed rails were applied.

C) The bed rail assessment form did not include questions related to any sleep assessment outcomes, falls history from bed, bed mobility or bed transfer status. These questions would assist the assessor in determining if the resident would benefit from a bed rail for bed mobility and transfers based on their status to use the bed rails for this purpose. Bed rails of any size are not a falls prevention device and increase the risk of a resident climbing over bed rails or getting lodged or entrapped by the bed rail as they attempted to roll off the bed. A section of the form was included that required the assessor to check off reasons for bed rail use and they included; staff, family/POA or resident expressed the need for bed rails, followed by whether the bed rail was considered a restraint or not. There were no risk over benefit questions requiring the assessor to document whether the interdisciplinary team deemed the bed rails to be of greater risk than if no bed rails were applied.

Resident #012 was identified to have specified responsive behaviours and cognitively impaired. No information was included in the bed rail assessment about the resident’s history of falls and whether they were from bed and whether a different bed system was trialled, whether specified falls prevention interventions were trialled or a different type of mattress. The POA and staff decided that the resident required specified bed rails to prevent falls from bed. No other information was included to establish the level of risk the resident had with or without bed rails. The resident was observed to be in bed on a specified date and was provided with a bed that could not be lowered to the floor.

D) The bed rail assessment form did not specify what interdisciplinary staff members participated in the evaluation of the residents. The assessment forms reviewed did not have any names listed on the form. According to the licensee’s bed rail policy, the RN conducts the resident assessment upon admission and the decision to use bed rails was a multidisciplinary decision based on information received from the resident or their power of attorney and a person from the Local Health Integrated Network (LHIN). No other key individuals were listed, especially those that provide direct care to the resident.

E) The most recent care plan for residents #011 and #013 did not include any direction for staff about the residents bed rail use, reasons for use, when bed rails were to be applied or how many and type of bed rails to be used. Both bed rail assessment forms included a check box that required the assessor to tick off whether the plan of care was updated. Both were checked off with a "yes". The licensee's policy included the requirement for the registered nurse to identify the reason for bed rail use and whether a restraint or not was to be included in the resident's plan of care.

The DOC identified that they felt pressured by the residents or their substitute decision maker to allow bed rails to remain on resident beds, despite the risks associated with certain bed rail types. The DOC stated the risks were explained to families or residents and they verbally consented to having the bed rails in place. As such, the licensee followed the direction received by certain individuals as opposed to the interdisciplinary team into their practices without balancing their obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by s. 15(1)(a) of O. Regulation 79/10.

The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with the identified prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)] (120)

2. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The long-term care home was equipped with approximately 31 bed systems that were verified by the owner of the home to have been purchased approximately 40 years ago. Most of these beds had two three-quarter length chrome bed rails attached to the frames. When in the raised position, the bed rails were loose by design. The tops of the bed rails could easily be nudged away from the edge of the mattress by approximately three inches while the bottom of the bed rail stayed in place, creating a "V" shape. The bed rails were not stable and could not be relied upon for stability.

The lowest horizontal bar within the rail frame curved upwards, creating an opening large enough for a small adult head. When the bed was flat, the opening was not a concern as it was below the top level of the mattress.

However, when the head of the bed was raised to a sitting position, the top of the mattress dropped to align with the opening in the bed rail. Resident's who are not able to maintain a seated position and move around on the bed may entrap a limb or their head within this opening.

According to the DOC, who evaluated the beds with the required tool used to measure entrapment zones, the area where the lowest horizontal bar curved upwards failed two separate zones of entrapment when the head of the bed was articulated upwards. All other areas of the bed passed entrapment. However, the DOC did not have any documentation of the bed system evaluation she completed, identifying the dates of the evaluation, the specific bed (with serial number or identifier), the specific mattress (with identifier) and the specific zones of entrapment (1 through 4) that were measured and either failed or passed entrapment.

The DOC reported that they tried to determine if another bed rail style could be added to the frame, but no other rails would fit to the existing holes on the bed frame from other bed manufacturers. Some bed rails were removed where residents and or their substitute decision makers (SDM) consented to their removal. Otherwise, if they did not, no other actions were taken to deal with the failed zones, whether to remove the bed rails entirely without resident or SDM consent or determine if an accessory would suitably seal the gap. Residents who used the bed rails were informed that the bed rails were a safety risk and if they agreed, they were permitted to use them at their own risk.

Three beds (two unoccupied and one occupied by residents) were observed with a portable bed rail on one side of the bed. All three were different and were not manufactured for the specific bed systems they were observed on. Portable bed rails are sold in retail stores for the purposes of domestic home use and are not permitted on adult hospital beds. The DOC felt that these portable bed rails, which were designed to slide under the mattress, were a suitable alternative for residents who could get out of bed independently. The home did not have enough bed systems with quarter bed rail options for all residents who chose to use a rail to transfer themselves in and out of bed. The DOC was not aware that the portable bed rails failed entrapment zone one, which is the space between the frames on either side of the portable rail. The DOC was unaware of how a resident may become entrapped on a portable rail until informed.

The licensee failed to ensure that where bed rails were used, steps were taken

to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The severity was a level 3, actual harm/actual risk as bed rails pose actual entrapment risk to residents. The scope was a level 3, widespread as all three of the bed rails reviewed did not meet the requirements related to the assessment of the bed rails. The compliance history was a level 1, as the home has not had previous non-compliance under this section. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

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 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

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

and the Director

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 30th day of June, 2020

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office