Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 12, 2017	2017_363659_0019	017538-17	Resident Quality Inspection

Licensee/Titulaire de permis

SHANTI ENTERPRISES LIMITED
600 White's Road PALMERSTON ON N0G 2P0

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

ROYAL TERRACE
600 White's Road PALMERSTON ON N0G 2P0

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

JANETM EVANS (659), ADAM CANN (634), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 8, 9, 10 and 11, 2017.

The following follow up and intakes were completed at the time of the RQI:
Log #029654-16, follow up to Compliance Order # 001, from inspection # 2016_448155_0012 related to the use of bed rails.
Log #008770-17/ Critical incident 2767-000004-17 related to a resident fall.
Log #0208783-16/ Critical incident 2767-000010-16 related to a resident fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Director of Recreation and Leisure, Registered Nurses, Registered Practical Nurse, the Resident Assessment Instrument Coordinator, Personal Support Workers and a Resident Council Representative.

The inspectors conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspectors observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the required Ministry of Health and Long-Term Care posted information and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

This inspection is follow up to Compliance Order #001, issued during Resident Quality inspection #2016_448155_0012.

The order stated: "The home shall prepare, submit and implement a plan to 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.

The plan must include how an identified resident and any other resident using bed rails will be assessed and how his or her bed system will be evaluated in accordance with evidence-based practices to minimize risk to the residents. The plan must also include who will be responsible for the ongoing bed system evaluations".

The licensee did not ensure that the residents were assessed in accordance with prevailing practices to minimize risk to the resident where bed rails were used. Prevailing practices includes a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Food and Drug Administration. On August 21, 2012, Long Term Care Homes were provided a memo

directing the use of the above document as a reference tool for best practice related to assessment and implementation of bed rail use.

Observations were conducted on a specified date of three resident rooms. Two resident's bed frame had bed rails attached and engaged in the up position. One resident's bed frame no longer had bed rails attached to their bed.

Review of the clinical record for the two identified resident's who had their bed rails engaged in an up position, showed that there was not a specific bed rail risk assessment completed.

In interviews completed with a Registered Practical Nurse (RPN) and the Director of Care (DOC) , they stated that the home continues to use the head to toe admission assessment as the assessment of the resident for use of bed rails. The DOC stated they believed this was sufficient for assessing the resident for the use of bed rails. The RPN stated they also completed a falls risk assessment with the admission head to toe assessment. Following this, the registered staff would use their clinical judgement and make a determination on the risk of the bed rail use for the resident. The RPN and DOC stated that there was not a specific resident assessment tool that the home utilized where bed rails are used.

Record review was completed of admission assessments for two identified residents. One resident's admission assessment did not mention bed rails and showed no evidence of a resident assessment for the actual use of bed rails. The second identified resident's admission assessment referred to bed rails related to the resident's preference of using one side rail but did not show documented evidence that the resident was assessed for the use of the rails

The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

The severity of this area of noncompliance was minimal risk of harm with potential for harm. The scope was pattern. This area of noncompliance was previously issued as a compliance order on October 5, 2016 during RQI #2016_448155_0012. [s. 15. (1) (a)]

Additional Required Actions:

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

Issued on this 17th day of October, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANETM EVANS (659), ADAM CANN (634), HELENE DESABRAIS (615)
Inspection No. / No de l'inspection :	2017_363659_0019
Log No. / No de registre :	017538-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 12, 2017
Licensee / Titulaire de permis :	SHANTI ENTERPRISES LIMITED 600 White's Road, PALMERSTON, ON, N0G-2P0
LTC Home / Foyer de SLD :	ROYAL TERRACE 600 White's Road, PALMERSTON, ON, N0G-2P0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelley Gould

To SHANTI ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_448155_0012, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that where bed rails are used, resident #006, #007 and every resident is assessed in accordance with evidence-based practices and, if there is none, in accordance with prevailing practices to minimize the risk to the resident.

Grounds / Motifs :

1. The licensee failed to comply with order #001, issued from inspection #2016_448155_0012 served on October 5, 2016.

The order stated: "The home shall prepare, submit and implement a plan to 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.

The plan must include how an identified resident and any other resident using bed rails will be assessed and how his or her bed system will be evaluated in accordance with evidence-based practices to minimize risk to the residents. The plan must also include who will be responsible for the ongoing bed system

evaluations".

The licensee did not ensure that the residents were assessed in accordance with prevailing practices to minimize risk to the resident where bed rails were used. Prevailing practices includes a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Food and Drug Administration. On August 21, 2012, Long Term Care Homes were provided a memo directing the use of the above document as a reference tool for best practice related to assessment and implementation of bed rail use.

Observations were conducted on a specified date of three resident rooms. Two resident's bed frame had bed rails attached and engaged in the up position. One resident's bed frame no longer had bed rails attached to their bed.

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Record review was completed of admission assessments for two identified residents. One resident's admission assessment did not mention bed rails and showed no evidence of a resident assessment for the actual use of bed rails. The second identified resident's admission assessment referred to bed rails related to the resident's preference of using one side rail but did not show documented evidence that the resident was assessed for the use of the rails

The licensee failed to ensure that where bed rails were used, the resident was

assessed in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

The severity of this area of noncompliance was minimal risk of harm with potential for harm. The scope was pattern. This area of noncompliance was previously issued as a compliance order on October 5, 2016 during RQI #2016_448155_0012. [s. 15. (1) (a)] (634)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 12th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

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