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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Hamilton Service Area Office
119 King Street West, 11th Floor
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2014	2014_189120_0023	H-000277-14	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

This inspection was conducted on the following date(s): April 16, 2014

An inspection #2014-189120-0007 was previously conducted on January 29, 2014 and an Order issued under s.15(2)(c) related to the condition of furnishings (beds and night tables) and associated auditing documentation. The Order was partially complied with and has been cleared however the remaining outstanding issues are identified below.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Supervisor and nursing staff.

During the course of the inspection, the inspector(s) toured all resident rooms, observed all bed systems, tested random bed side rails, observed the condition of night side tables and reviewed resident care records, resident bed rail assessment and bed safety audit records.

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

Findings of Non-Compliance were found during this inspection.

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

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

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

Findings/Faits saillants :

1. The licensee did not assess all residents who use one or more bed side rails in accordance with prevailing practices to minimize risk to the resident.

A registered staff member of the home completed resident bed rail use assessments in February 2014. The staff member was not available for interview at the time of the inspection to determine how the assessments were completed and if they included prevailing practices identified in the Food and Drug Administration's "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings, April 2003". The guideline has been endorsed by Health Canada and is currently the only document with comprehensive information regarding bed safety and bed rail use. Upon review of the documentation used by the home, it did not appear that the guidelines were incorporated into the assessment process and associated forms. It did not include an interdisciplinary approach to a final decision nor did it incorporate many of the questions identified in the guideline.

Documentation made available at the time of inspection included a "Bed Audit" list dated March 31, 2014 identifying which residents required rails, how many they required, the size and the reason. A form titled "Side Rail and Alternative Equipment Decision Tree" was also used during the assessment but a number of residents located in 6 different rooms did not have the form completed for them and many of the forms were not dated. Several of these residents instead had a notation in the care plan identifying that an assessment was completed on a particular date. Three out of the four decision tree options all led the evaluator to "refer the resident to a nurse/Physiotherapist/Occupational Therapist" to determine if the resident required a fall mat, hi-low bed, appropriate side rail length, removal of side rail or other. The evaluator decided that 32 residents should have their rails removed and 37 residents would keep their rails for their assessed needs. An RN (Registered Nurse) evaluated the residents but an interdisciplinary team did not participate in the assessments.

The guideline refers to minimizing or not using the bed rails but does not suggest that they be completely removed for various reasons. Resident's health, mobility and cognitive status change on a regular basis and therefore resident's bed rail needs will change and should be made readily available when necessary. In particular, one identified resident was observed lying in bed with both of their assist rails in the engaged position on April 16, 2014. The resident's plan of care stated that they required extensive assistance of 2 staff for bed mobility however the plan did not address the use of rails at all.

No documentation could be provided at the time of inspection as to whether or not the beds were all re-tested for zones of entrapment once changes had been made to the beds (new foam mattresses added, mattress keepers added, rails either tightened or replaced, new beds received). Beds identified by the inspector in 8 different rooms were all equipped with side rails and residents were identified to require the use of the side rails when in bed. No confirmation could be provided by the home that the beds passed all 4 zones of entrapment relating to bed rails. Failure to retest the beds after any changes have been made may result in increased risk of residents becoming trapped between the bed rail and mattress.

Post inspection, on May 5, 2014, the administrator advised by email that the beds had been re-tested (no date provided) and that 3 of the beds failed one or more zones of entrapment (no specific zones provided). No response was received as to the date of the bed audit and the specific bed locations, however the administrator reported that action was taken to ensure each resident twas on a safe bed. On May 8, 2014, the maintenance person who completed the audit was contacted. He was asked to fax the bed entrapment audit results which was completed on May 1, 2014. The audit however did not provide information as to which zones of entrapment the beds passed or failed and which specific bed failed. The information only described whether the resident used rails or not and whether the rail was removed from the bed or not. The maintenance person confirmed that several beds failed one or more zones of entrapment which were immediately exchanged with a bed that passed all 4 zones of entrapment or had the bed side rails removed thereby eliminating resident risk. Arrangements were made to have all of the beds re-tested by an external bed supplier on May 9, 2014 who will be able to provide the necessary details. [s. 15(1)(a)]

Additional Required Actions:

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

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

Ontario

Ministry of Health and Long-Term Care

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COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS			
REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2014_189120_0007	120

Issued on this 20th day of May, 2014

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

B. Susnik

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2014_189120_0023
Log No. / Registre no:	H-000277-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 8, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BRIERWOOD GARDENS 425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHERINE DONAHUE

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall submit the following documentation:

1. Provide documentation that confirms that each resident bed has passed all four zones of entrapment, 1 through 4. The documentation shall detail the serial number of the bed, the bed location, the type of mattress on the bed, the type and number of bed rails on the bed, the date of the test, the name of the tester and whether zones 1 through 4 have passed or failed and any follow-up action.
2. Provide a copy of the home's policy on how resident bed rail use assessments are completed that incorporate the guidelines identified in the "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings, April 2003".

The above documentation shall be submitted to Bernadette Susnik by email Bernadette.susnik@ontario.ca or fax to 905-546-8255 by May 30, 2014.

Grounds / Motifs :

1. Previously issued on February 13, 2014 on inspection report #2014-189120-0007 under s.15(2)(c) related to bed safety and associated documentation (under item #3 and 4).

1. The licensee did not assess all residents who use one or more bed side rails

in accordance with prevailing practices to minimize risk to the resident.

A registered staff member of the home completed resident bed rail use assessments in February 2014. The staff member was not available for interview at the time of the inspection to determine how the assessments were completed and if they included prevailing practices identified in the Food and Drug Administration's "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings, April 2003". The guideline has been endorsed by Health Canada and is currently the only document with comprehensive information regarding bed safety and bed rail use. Upon review of the documentation used by the home, it did not appear that the guidelines were incorporated into the assessment process and associated forms. It did not include an interdisciplinary approach to a final decision nor did it incorporate many of the questions identified in the guideline.

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This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 8th day of May, 2014

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

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

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