**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
HAMILTON ON L8P 4Y7
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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 26, 2016 | 2015_189120_0099 | 012131, 012135-15 | 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**

GARDEN CITY MANOR
168 Scott Street St. Catharines ON L2N 1H2

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

BERNADETTE SUSNIK (120)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): December 29 & 30, 2015**

**An inspection (RQI 2015-341583-0006) was previously conducted March 24 to April 10, 2015 at which time non-compliance was identified and Orders issued regarding bed safety (Order #002) and cleaning and disinfecting personal care devices (Order #004). For this follow-up inspection, one out of four separate conditions laid out in Order #004 was not met and is identified below. The conditions laid out in Order #002 were not fully met and the Order was revised and is being re-issued.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, Environmental Services Manager, Infection Control Designate, Physiotherapist and residents.**

**During the course of the inspection, the inspector toured soiled utility rooms, tub/shower rooms, random resident washrooms, random resident bedrooms, observed the home's bed systems, observed the sanitation level of personal care articles, reviewed bed safety audit reports, several resident care plans and resident clinical assessments related to bed rail use and reviewed documents developed and presented to employees regarding cleaning and disinfecting personal care articles.**

**The following Inspection Protocols were used during this inspection:**
**Infection Prevention and Control**
**Safe and Secure Home**

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

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

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 87. (2) | CO #004 | 2015_341583_0006 | 120 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

A) Resident bed systems were assessed for entrapment zone risks on May 13, 2015 by an external contractor using a specialized tool as per Health Canada's Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006". According to the records, 13 beds did not pass all four zones of entrapment.  The failed beds subsequently received either mattress keepers or a new style of mattress to ensure they passed zones 2, 3 and 4.  No re-tests were conducted on the 13 beds to confirm that the beds passed.  The licensee based the status of the beds on advice given by the external contractor that the beds would pass the 3 zones of entrapment if they completed the work noted above.

B) During the inspection, rotating assist bed rails on 8 identified beds were very loose and when rotated into the guard position, pulled away from the mattress very easily, and created a large gap of about 4 inches between the bed rail and the mattress.  Each of the residents occupying these beds had signs on their over bed light stating that they required either one or both bed rails while in bed.  Entrapment risk was therefore higher for these residents.  When reported to the Physiotherapist and Environmental Services Manager (ESM), neither were aware of the condition of the bed rails.  The ESM reported that no documentation or reports were completed by health care or housekeeping staff that the bed rails were loose.  According to records and interviews, all staff received training in July and August 2015 which specified that they were responsible to report and document in the maintenance log any bed maintenance and safety related issues such as loose rails, malfunctioning rails, remote control issues, brakes not working etc.

The strategy or plan developed and implemented by the licensee to monitor the condition of the beds and bed rails was not followed by health care and housekeeping staff and steps were therefore not taken to prevent possible resident entrapment. [s. 15. (1) (b)]

***Additional Required Actions:***

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

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**WN #2:  The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:**
**(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,**
**(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and**
**(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were developed for the cleaning and disinfection of supplies and devices such as bed pans, wash basins and urinals in accordance with best practices.

According to a document titled "Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, 2013", non-critical devices such as bed pans, wash basins and urinals are to be cleaned and disinfected with a low level disinfectant after each use (unless the device is not used by any other person whereby cleaning is sufficient) and clear instructions shall be developed describing how the devices are to be cleaned and disinfected.

During the inspection, cleaning and disinfection procedures for the above noted devices were observed to be posted in the soiled utility rooms, however the instructions were not customized to the procedures that were developed and taught to the direct care staff in the home. According to the home's infection control designate(ICD), he had not revised them before the compliance due date of September 30, 2015 as stated in Order #004 or by the time the follow-up inspection was completed. He reported that he was planning to revise the procedures to reflect the current process in the home.

The ICD provided for review a series of slides which were used to teach direct care staff

on the process and expectations of cleaning and disinfecting devices. According to the slides and the ICD, staff were directed to label wash basins, bed pans and urinals with the resident's name and in addition, urinals and bed pans were required to be labeled with a date that the device was given to the resident. The wash basins were to be rinsed and disinfected after each use by using a disinfectant wipe located in each resident washroom. Urinals were to be rinsed after use or discarded immediately if visibly stained. Bed pans were to be taken to the soiled utility room for cleaning followed by disinfection. The bed pans were to be cleaned with soap and water in the hopper using a brush, rinsed and wiped down with a disinfectant wipe.

After one week, the urinals and bed pans were to be automatically discarded and after one month, the wash basins were to be discarded.

No formal written procedure or policy was developed for staff regarding the above noted tasks and were not available for review at time of inspection. One condition out of four identified in Order #004 previously required the licensee to develop written procedures and to implement them by September 30, 2015. Due to compliance with the other three conditions and notable improvements in the home with respect to staff adherence to the storage, handling and sanitation of the devices, the Order was closed but the requirement to develop a written formal policy and procedure for cleaning and disinfection of the devices remains outstanding. [s. 87(2)(b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written procedures are developed for the cleaning and disinfection of supplies and devices such as bed pans, wash basins and urinals in accordance with best practices, to be implemented voluntarily.***

**Issued on this 8th day of February, 2016**

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

**Original report signed by the inspector.**

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 :** | 2015_189120_0099 |
| **Log No. / Registre no:** | 012131, 012135-15 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Jan 26, 2016 |
| **Licensee / Titulaire de permis :** | REVERA LONG TERM CARE INC.<br>55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2 |
| **LTC Home / Foyer de SLD :** | GARDEN CITY MANOR<br>168 Scott Street, St. Catharines, ON, L2N-1H2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | KIM WIDDICOMBE |

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

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**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2015_341583_0006, CO #002;

**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 complete the following:

1. Establish a list of all beds that are equipped with rotating assist rails that are prone to loosening.
2. Establish a list of all residents who occupy any of the identified beds with bed rails prone to loosening and verify if they require one or more bed rails at any time.

For those residents who were assessed as requiring one or more bed rails and occupy a bed identified in #1 above, the resident must be accommodated with a different style of secure bed rail or bed or be equipped with a rotating assist bed rail that remains secure at all times.

**Grounds / Motifs :**

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

A) Resident bed systems were assessed for entrapment zone risks on May 13, 2015 by an external contractor using a specialized tool as per Health Canada's Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006". According to the records, 13 beds did not pass all four zones of entrapment. The failed beds subsequently received either mattress keepers or a new style of mattress to ensure they passed zones 2, 3 and 4. No re-tests were conducted on the 13 beds to confirm that the beds passed. The licensee based the status of the beds on advice given by the external contractor that the beds would pass the 3 zones of entrapment if they completed the work noted above.

B) During the inspection, rotating assist bed rails on 8 identified beds were very loose and when rotated into the guard position, pulled away from the mattress very easily, and created a large gap of about 4 inches between the bed rail and the mattress. Each of the residents occupying these beds had signs on their over bed light stating that they required either one or both bed rails while in bed. Entrapment risk was therefore higher for these residents. When reported to the Physiotherapist and Environmental Services Manager (ESM), neither were aware of the condition of the bed rails. The ESM reported that no documentation or reports were completed by health care or housekeeping staff that the bed rails were loose. According to records and interviews, all staff received training in July and August 2015 which specified that they were responsible to report and document in the maintenance log any bed maintenance and safety related issues such as loose rails, malfunctioning rails, remote control issues, brakes not working etc.

The strategy or plan developed and implemented by the licensee to monitor the condition of the beds and bed rails was not followed by health care and housekeeping staff and steps were therefore not taken to prevent possible resident entrapment. (120)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 29, 2016

## 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 26th day of January, 2016**

**Signature of Inspector / Signature de l'inspecteur :**

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

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