Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**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
Telephone: (905) 546-8294
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Bureau régional de services de Hamilton
119, rue King Ouest, 11ième étage
HAMILTON, ON, L8P-4Y7
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**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Oct 4, 5, 9, 2012 | 2012_189120_0001 | 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**

WEST OAK VILLAGE
2370 THIRD LINE, OAKVILLE, ON, L6M-4E2

**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.**

**During the course of the inspection, the inspector(s) spoke with the executive director, director of care, assistant director of care/staff educator, environmental services supervisor, registered and non-registered staff regarding bed safety. An Order #001 was previously issued on June 2012 for non-compliance with Ontario Regulation 79/10 relating to bed safety. The requirements of that Order have not been met for this inspection and are being re-issued.**

**During the course of the inspection, the inspector(s) toured all home areas and random resident rooms to review bed systems, reviewed bed safety audit reports, the home's least restraint and restraint reduction protocols and bed manufacturer's guidelines. (H-001173-12)**

**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 | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | 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 subsections:**

**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).**

**Findings/Faits saillants :**

[O. Reg. 79/10, s. 15(1)(a)] The licensee of a long-term care home has not ensured that where bed rails are used,

(a) the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

The home has not assessed each resident with respect to their bed rail use, however the home has evaluated the bed system (mattress, rails, head & foot boards, frame). All beds were evaluated on May 31, 2012 for safety by a representative from a bed manufacturer who used Health Canada's Guidelines titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Reliability and Other Hazards" to guide their inspection. Based on the summary of the bed audit dated May 31, 2012, 101 beds failed acceptable safety parameters known as "zones of entrapment". Health Canada's guidelines require that beds be tested in 7 areas or zones and these relate to mattress compressibility, lateral shift of the mattress (fit) or rail shift and degree of play from loosened rails.

Residents who continue to use or have bed rails applied when in bed, have not been assessed for any other bed safety factors except for the prevention of falls, according to the nurse educator and director of care. The home does have a guideline titled "Strategies to Manage Bed Zones of Entrapment" which may be used to evaluate residents, however it is not comprehensive and does not include how to make an assessment based on the resident's medical background, behaviours and sleeping habits.

[O. reg. 79/10, s. 15(1)(b)] The licensee of a long-term care home has not ensure that where bed rails are used,

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On June 5, 2012, the home submitted a response plan to an Order issued on May 28, 2012 with respect to mitigating risks to residents who sleep in beds that have failed at least one zone of entrapment. The commitment received was that residents would be assessed and their bed rails secured to reduce the entrapment issues. This was not identified during the inspection.

The immediate steps that have been taken to date to address the various zones of entrapment (identified by their bed audit conducted on May 31, 2012), has been to secure the bed rails with zip ties (so that staff do not use the rails) and to install mattress keepers on all of the beds that previously did not have them. During the inspection, mattress keepers were identified to be in place, however the mattress keepers have not been able to mitigate entirely the zone 2 and 4 entrapment gaps. These gaps are related to the density of the mattress itself. During the tour of the home, no zip ties could be seen on rails, many rails were seen in the up position and several random beds were selected where bed rails could easily be moved up and down. When 9 registered and non-registered staff were interviewed regarding the use of bed rails in the home, some staff indicated that anywhere from 5 to "the majority" of their residents have bed rails applied when in bed. The use of bed rails therefore continues with beds that have not passed safety guidelines.

Adequate steps to mitigate zone 2 and 4 entrapment risks have not been taken. The home was only able to demonstrate that they had future plans to purchase new mattresses and beds.

***Additional Required Actions:***

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

**Issued on this 9th day of October, 2012**

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

B. Susnik

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

**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 :** | 2012_189120_0001 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Date of Inspection / Date de l'inspection :** | Oct 4, 5, 9, 2012 |
| **Licensee / Titulaire de permis :** | REVERA LONG TERM CARE INC.<br>55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2 |
| **LTC Home / Foyer de SLD :** | WEST OAK VILLAGE<br>2370 THIRD LINE, OAKVILLE, ON, L6M-4E2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | DIANE FITZPATRICK |

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

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**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:

1) Institute immediately, appropriate measures (in accordance with evidence-based practices such as Health Canada's Guidance Document entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and other Hazards") to reduce or mitigate potential risks to residents who currently sleep on a bed system, where bed rails are used, that did not pass all 7 zones of entrapment (based on the latest bed safety audit).

2) Develop an interdisciplinary clinical risk assessment tool which takes into consideration resident's medical needs, comfort, and freedom of movement for a safe bed environment. The tool is to be used to determine what type of bed system is appropriate for the resident. Each resident is to be assessed using the tool. The Order is to be complied with by November 15, 2012.

3) Each resident's plan of care shall be updated to identify the bed safety interventions that are appropriate for them, as well as those interventions that are not effective, if they were previously attempted and determined not to be appropriate for the resident. The Order is to be complied with by November 15, 2012.

**Grounds / Motifs :**

1. The licensee of the home did not ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

On June 5, 2012, the home submitted a response plan to an Order issued on May 28, 2012 with respect to mitigating risks to residents who sleep in beds that have failed at least one zone of entrapment. The commitment received was that residents would be assessed and their bed rails secured to reduce the entrapment issues. This was not identified during the inspection.

The immediate steps that have been taken to date to address the various zones of entrapment (identified by their bed audit conducted on May 31, 2012), has been to secure the bed rails with zip ties (so that staff do not use the rails) and to install mattress keepers on all of the beds that previously did not have them. During the inspection, mattress keepers were identified to be in place, however the mattress keepers have not been able to mitigate entirely the zone 2 and 4 entrapment gaps. These gaps are related to the density of the mattress itself. During the tour of the home, no zip ties could be seen on rails, many rails were seen in the up position and several random beds were selected where bed rails could easily be moved up and down. When 9 registered and non-registered staff were interviewed regarding the use of bed rails in the home, some staff indicated that anywhere from 5 to "the majority" of their residents have bed rails applied when in bed. The use of bed rails therefore continues with beds that have not passed safety guidelines.

Adequate steps to mitigate zone 2 and 4 entrapment risks have not been taken. The home was only able to demonstrate that they had future plans to purchase new mattresses and beds. (120)
2. The licensee of a long-term care home did not ensure that where bed rails are used,

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The home has not assessed each resident with respect to their bed rail use, however the home has evaluated the bed system (mattress, rails, head & foot boards, frame). All beds were evaluated on May 31, 2012 for safety by a representative from a bed manufacturer who used Health Canada's Guidelines titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Reliability and Other Hazards" to guide their inspection. Based on the summary of the bed audit dated May 31, 2012, 101 beds failed acceptable safety parameters known as "zones of entrapment". Health Canada's guidelines require that beds be tested in 7 areas or zones and these relate to mattress compressibility, lateral shift of the mattress (fit) or rail shift and degree of play from loosened rails.

Residents who continue to use or have bed rails applied when in bed, have not been assessed for any other bed safety factors except for the prevention of falls, according to the nurse educator and director of care. The home does have a guideline titled "Strategies to Manage Bed Zones of Entrapment" which may be used to evaluate residents, however it is not comprehensive and does not include how to make an assessment based on the resident's medical background, behaviours and sleeping habits. (120)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 15, 2012

## 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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 9th day of October, 2012**

**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