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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 13, 2013	2013_189120_0050	H-002216-12	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), SHARLEE MCNALLY (141)

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): July 26 & 29, 2013

Inspections (2012-072120-0030 & 2012-189120-0001) were previously conducted on April 5 and October 4, 2012 regarding bed safety and bed rail use. Order #001 was issued on May 28, 2012. On the follow-up visit on October 4, 2012, the Order remained non-compliant and was revised and issued on October 9, 2012. For this follow-up visit, the Order has not been complied with and the attached Orders #001 and #002 are being issued.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), RAI-MDS Co-ordinator, Registered Nurses and Registered Practical Nurses, Environmental Services Supervisor and Personal Support Workers.

During the course of the inspection, the inspector(s) toured the home and randomly checked resident beds, reviewed bed safety audit results and the home's policies and procedures on restraints, bed safety and bed rail use.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

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 :

Where bed rails are used, steps have not been taken to prevent resident entrapment, taking into consideration all potential zone of entrapment.

On May 31, 2012, a bed entrapment zone audit was completed by an outside contractor. The audit results indicated that 123 beds failed one or more zones of entrapment. In response to the information, the home installed mattress keepers, tightened bed rails and ordered and replaced all 123 mattresses. However, since the interventions were instituted, an audit to confirm that the beds were free of entrapment zones has not been completed. During the inspection, it was confirmed with management staff that 10 residents used a therapeutic surface which did not pass entrapment zone testing. Several of the residents were witnessed to be lying in bed with one or more rails in the up position on July 26, 2013 without any bolsters or other accessories as interventions to mitigate potential risks of entrapment. The Director of Care confirmed that residents on a therapeutic mattress have not been assessed for bed safety (where rails are in use). [s. 15(1)(b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Resident #002 was not re-assessed and their plan of care reviewed and revised when the resident's care needs changed and at least quarterly.

The resident was assessed on October 22, 2012 as requiring a half bed rail up on both sides of the bed when in bed. The resident was observed on July 26, 2013 to have both three quarter padded bed rails up on their bed. The resident's plan of care identified the use of both three quarter bed rails to aid in mobility but identified under the bed mobility focus in the plan of care that the resident required two person physical assist. Staff confirmed that the resident used both three quarter bed rails and was unable to unlatch them independently.

There was no documented evidence in the resident's records that a re-assessment was completed after October 22, 2012 to assess resident's need for change from one half bed rails to three quarter bed rails.

There was no subsequent re-assessments completed quarterly in the Resident Assessment Instrument Minimum Data Set (RAI-MDS) and there was no triggered Resident Assessment Protocol (RAP) for the use of bed rails as per the home's policy and procedure related to the completion of quarterly assessments.
[s.6(10)(b)]

2. Resident #003 was not re-assessed and their plan of care reviewed and revised when the resident's care needs changed and at least quarterly.

The resident was assessed on October 22, 2012 as requiring half bed rails up on both sides of the bed when in bed. The resident was observed on July 26, 2013 to have both three quarter padded bed rails on their bed. The resident's plan of care identified the use of both three quarter bed rails for safety to define bed parameters. There was no documented evidence in the resident's records that a re-assessment was completed after October 22, 2012 to assess resident's need for change from half bed rails to three quarter bed rails.

There was no subsequent re-assessments completed on the quarterly RAI-MDS and there was no triggered RAP for the use of bed rails. [s. 6(10)(b)]

3. Resident #004 was not re-assessed and their plan of care reviewed and revised at least quarterly.

The resident was assessed on October 22, 2012 as requiring three quarter bed rails up on both sides of the bed when in bed. The resident was observed on July 26, 2013 to have three quarter padded bed rails on his bed. The resident's plan of care identified the use of three quarter bed rails for safety. There was no subsequent re-assessments completed on the quarterly RAI-MDS and there was no triggered RAP for the use of bed rails. [s. 6(10)(b)]

4. Resident #005 was not re-assessed and their plan of care reviewed and revised when the resident's care needs changed and at least quarterly.

The resident was assessed on October 22, 2012 as requiring no bed rails up when in bed. The resident was observed on July 26, 2013 to have both three quarter padded bed rails on their bed. The resident's plan of care identified the use of three quarter bed rails for safety. There was no documented evidence in the resident's records that a re-assessment was completed after October 22, 2012 to assess resident's need for change from one half bed rails to three quarter bed rails.

There was no subsequent reassessments completed on the quarterly RAI-MDS and there was no triggered RAP for the use of bed rails. [s. 6(10)(b)]

5. Resident #006 was not re-assessed and their plan of care reviewed and revised at least quarterly.

The resident was assessed on October 22, 2012 as requiring three quarter bed rails up on both sides of the bed when in bed. The resident was observed in bed on July 26, 2013 and had both three quarter padded bed rails in the raised position. The resident's plan of care identified the use of three quarter bed rails when in bed. There was no subsequent re-assessments completed on the quarterly RAI-MDS and there was no triggered RAP for the use of bed rails.

The DOC confirmed that re-assessments should occur at time of change and quarterly related to three quarter bed rail usage. [s. 6(10)(b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 13th day of August, 2013

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

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), SHARLEE MCNALLY (141)
Inspection No. / No de l'inspection :	2013_189120_0050
Log No. / Registre no:	H-002216-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 13, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	WEST OAK VILLAGE 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:

Order # /
Ordre no : 001

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

Linked to Existing Order /
Lien vers ordre existant: 2012_072120_0030, CO #001;
2012_189120_0001, 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:

1. Re-assess all beds to determine current bed safety risks using Health Canada Guidelines titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Reliability and Other Hazards".
2. Submit to the inspector, a copy of the audit and any interventions that need to be taken to mitigate any identified risks.
3. Where risks have been identified, include in the resident's plan of care, the specific risk identified and the specific interventions taken to mitigate the risks for that particular resident.
4. Establish a resident re-assessment process when there is a change in resident status.
5. Establish a program to re-evaluate the bed systems at regular intervals, especially when a change is made to the bed (change of mattress or rail).

The Order shall be complied with by August 30, 2013.

All requested submissions shall be sent to the attention of Bernadette Susnik, LTC Homes Inspector, Ministry of Health and Long Term Care, Performance and Improvement and Compliance Branch, 119 King St. W, 11th Floor, Hamilton, ON L8P 4Y7 or by email to Bernadette.Susnik@Ontario.ca.

Note: Requests to extend the compliance order date shall be made at least one week prior to the expiry of the original order.

Grounds / Motifs :

1. Where bed rails are used, steps have not been taken to prevent resident entrapment, taking into consideration all potential zone of entrapment.

On May 31, 2012, a bed entrapment zone audit was completed by an outside contractor. The audit results indicated that 123 beds failed one or more zones of entrapment. In response to the information, the home installed mattress keepers, tightened bed rails and ordered and replaced all 123 mattresses. However, since the interventions were instituted, an audit to confirm that the beds were free of entrapment zones has not been completed. During the inspection, it was confirmed with management staff that 10 residents used a therapeutic surface which did not pass entrapment zone testing. Several of the residents were witnessed to be lying in bed with one or more rails in the up position on July 26, 2013 without any bolsters or other accessories as interventions to mitigate potential risks of entrapment. The Director of Care confirmed that residents on a therapeutic mattress have not been assessed for bed safety (where rails are in use). (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure each resident including resident #002, #003, #004, #005, and #006 are;

1. Assessed for the use of three quarter bed rails when implemented.
2. Re-assessed quarterly to identify the required need for continuation of the plan of care related to three quarter bed rail usage.

The plan shall be submitted by August 15, 2013 to Long Term Care Inspector Sharlee McNally at: Sharlee.McNally@ontario.ca

Grounds / Motifs :

1. Resident #002 was not re-assessed and their plan of care reviewed and revised when the resident's care needs changed and at least quarterly.

The resident was assessed on October 22, 2012 as requiring a half bed rail up on both sides of the bed when in bed. The resident was observed on July 26, 2013 to have both three quarter padded bed rails up on their bed. The resident's plan of care identified the use of both three quarter bed rails to aid in mobility but identified under the bed mobility focus in the plan of care that the resident required two person physical assist. Staff confirmed that the resident used both three quarter bed rails and was unable to unlatch them independently.

There was no documented evidence in the resident's records that a re-assessment was completed after October 22, 2012 to assess resident's need for change from one half bed rails to three quarter bed rails.

There was no subsequent re-assessments completed quarterly in the Resident Assessment Instrument Minimum Data Set (RAI-MDS) and there was no triggered Resident Assessment Protocol (RAP) for the use of bed rails as per the home's policy and procedure related to quarterly assessments. (141)

2. Resident #003 was not re-assessed and their plan of care reviewed and revised when the resident's care needs changed and at least quarterly.

The resident was assessed on October 22, 2012 as requiring half bed rails up on both sides of the bed when in bed. The resident was observed on July 26, 2013 to have both three quarter padded bed rails on their bed. The resident's plan of care identified the use of both three quarter bed rails for safety to define bed parameters. There was no documented evidence in the resident's records that a re-assessment was completed after October 22, 2012 to assess resident's need for change from half bed rails to three quarter bed rails.

There was no subsequent re-assessments completed on the quarterly RAI-MDS and there was no triggered RAP for the use of bed rails. (141)

3. Resident #004 was not re-assessed and their plan of care reviewed and revised at least quarterly.

The resident was assessed on October 22, 2012 as requiring three quarter bed rails up on both sides of the bed when in bed. The resident was observed on July 26, 2013 to have three quarter padded bed rails on his bed. The resident's plan of care identified the use of three quarter bed rails for safety. There was no subsequent re-assessments completed on the quarterly RAI-MDS and there was no triggered RAP for the use of bed rails. (141)

4. Resident #005 was not re-assessed and their plan of care reviewed and revised when the resident's care needs changed and at least quarterly.

The resident was assessed on October 22, 2012 as requiring no bed rails up when in bed.

The resident was observed on July 26, 2013 to have both three quarter padded bed rails on their bed. The resident's plan of care identified the use of three quarter bed rails for safety. There was no documented evidence in the resident's records that a re-assessment was completed after October 22, 2012 to assess resident's need for change from one half bed rails to three quarter bed rails.

There was no subsequent reassessments completed on the quarterly RAI-MDS and there was no triggered RAP for the use of bed rails. (141)

5. Resident #006 was not re-assessed and their plan of care reviewed and revised at least quarterly.

The resident was assessed on October 22, 2012 as requiring three quarter bed rails up on both sides of the bed when in bed. The resident was observed in bed on July 26, 2013 and had both three quarter padded bed rails in the raised position. The resident's plan of care identified the use of three quarter bed rails when in bed. There was no subsequent re-assessments completed on the quarterly RAI-MDS and there was no triggered RAP for the use of bed rails.

The DOC confirmed that re-assessments should occur at time of change and quarterly related to three quarter bed rail usage. (141)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 23, 2013

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.

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

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 13th day of August, 2013

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