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

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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
Mar 16, 2017	2017_548592_0006	003066-17	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

WOODLAND VILLA
30 Milles Roches Road R. R. #1 Long Sault ON K0C 1P0

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

MELANIE SARRAZIN (592), AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), MICHELLE JONES (655)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 13, 14, 15, 16, 17, 21, 22, 23, 24, 27 and 28, 2017

The following Critical Incidents were inspected concurrently during this inspection:
Log # 025150-16 related to missing resident
Log # 025822-16 related to an alleged resident to resident sexual abuse incident
Log # 030184-16 related to adverse medication incident
Log # 002747-17 related to an injury which the resident was taken to the hospital and one complaint was inspected concurrently during this Inspection, Log # 034697-16 related to minimizing of restraints and personal support services

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, a member of Residents' Council, Personal Support Workers (PSW), Registered Practical Nurses (RPN),Registered Nurses (RN), Food Service Worker, Housekeeping Aide, Maintenance staff, Environmental Service Supervisor, Dietitian, Nutritional Manager, Life Enrichment Coordinator, Clinical Care Coordinator, Administration Services Manager and the Administrator.

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, relevant licensee policies and procedures, staff work routines, posted menus, observed resident rooms, resident common areas, the Admission process and Quality Improvement system, Residents' Council and Family Council minutes, a medication administration pass, one meal service, the delivery of resident care and services and staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **10 WN(s)**
- **3 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 are used, the resident has been 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 August 21, 2012, a letter was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the letter, it is written that this HC Guidance document is expected to be used by Long-Term Care Homes "as a best practice document" for assessig residents and evaluating bed systems. The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States.

The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is recommended that

any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including the resident's medical needs, sleep habits and patterns, sleep environment, resident comfort in bed, and potential safety risks posed by using one or more bed rails.

The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Inspector #655 observed the beds belonging to residents #033, #034, #036 and #040 over the course of the inspection.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #033. At the time of the observation, two ¼ length bed rails were observed to be in the up position.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #034. At the time of the observation, two bed rails were observed to be in the up position. From the foot of the bed, the left rail was 1/4 length positioned in a vertical position; and the right rail was a ¼ length rail. On February 21, 2017, the same bed rails were observed to be in the up position.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #036. At the time of the observation, two ¼ length bed rails were observed to be in the up position. On February 21, 2017, Inspector #655 observed the two ¼ length bed rails to again be in the up position. During an interview on the same day, resident #036 indicated to Inspector #655 that his/her bed rails are normally in the up position, and that they had been used this way since the time of his/her admission. Resident #036 was admitted to the home in 2013.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #040. At the time of the observation, two bed rails were observed to be in the up position. From the foot of the bed, there was a ¾ length bed rail on the left side, and an assist rail

on the right side. On February 21, 2017, both bed rails were again observed to be in the up position.

Inspector #655 reviewed the health care records of residents' #033, #034, #036 and #040, and located a "Side-Rail Use Assessment Form" for each resident. The side-rail use assessment forms for three out of four residents (resident #s 034, 036, 040) were observed by Inspector #655 to be incomplete in that one or more of the following data were missing: alternative interventions, rationale for the use of bed rails, recommendation for the type of bed rail to be used, signatures. All three forms were dated April, 2016.

During an interview on February 16, 2017, RPN #103 indicated to Inspector #655 that the side-rail use assessment forms are completed for each resident at the time of the residents' admission.

On February 17, 2016, Inspector #655 reviewed the side-rail use assessment form for resident #034, who was admitted to the home in 2016, with RPN #103. RPN# 103 was, at the time of the interview, responsible for completing the admission processes for new resident admissions to the home. The side-rail use assessment form for resident #034 was also dated April 2016. RPN #103 indicated to Inspector #655 that the side-rail use assessment form that had been filled in for resident #034 was considered incomplete, in that all yes/no questions on the form are expected to be answered; and in this case, they were not. Both RPN #103 and Inspector #655 reviewed the second page of the side-rail use assessment form, which was also incomplete in that there was no recommendation made for the type of bed rail to be used, and no signatures. RPN #103 indicated to Inspector #655 that when she uses the side-rail use assessment form, she does not complete page two. RPN #103 explained that the staff refrain from making a recommendation for the type of bed rail to be used for residents due to a lack of expertise related to bed rail type; and indicated that instead, staff would defer to the residents and/or family's request in determining what type of bed rail to use.

During an interview on February 17, 2017, the DOC/Administrator indicated to Inspector #655 that the "Side-Rail Use Assessment Form" – the same form that was observed to be incomplete for all three of the above mentioned residents who currently use bed rails, was intended to be used to assess both the residents need for the bed rail and the residents' safety in using a bed rail (s).

On review by Inspector #655 on February 23, 2017, it was found that the "Side-Rail Use

Assessment Form" currently in use by the licensee was not fully in accordance with the prevailing practices identified in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S.FDA, 2003), a companion to the HC Guidance Document. The current "Side-Rail Use Assessment Form", for example, did not address such factors as the residents sleep patterns or habits, the residents' sleep environment or level of comfort in bed. In addition, no clear documentation of a risk-benefit analysis was observed on the side-rail use assessment forms or elsewhere in the healthcare records of resident #s 033, 034, 036 or 040. During an interview on February 23, 2017, the DOC/Administrator acknowledged the same. At the same time, the DOC/Administrator acknowledged that the current "Side-Rail Use Assessment Form" was implemented in April, 2016 and was the most current one; and prior to that time, residents - such as resident #036 who was using bed rails since his/her admission in 2013 - were not necessarily assessed for bed rail use before bed rails were implemented. The Administrator provided to the Inspector a copy of the policy titled "Bed Rails" (CS-18.12), dated January, 2011. At that the Administrator indicated that this was the most recent policy used at the home.

Inspector #655 reviewed the policy. In the policy, it is stated: "each resident shall be assessed individually to determine the need for their bed rails to be up". The policy did not reference the side rail use assessment form currently in use at the home; nor did it speak to the process of performing and documenting a risk-benefit analysis as it relates to each residents' use of bed rails.

In summary, residents, including resident #s 033, 034, 036, and 040, were not assessed for the use of bed rails in accordance with prevailing practices to minimize risk to the resident.

In addition to providing guidance in establishing a clinical assessment where bed rails are used, the HC Guidance Document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools (the cone and cylinder tool) and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

A total of 114 bed systems in the home were evaluated in accordance with the methods outlined in the HC Guidance Document in July, 2016. The bed system evaluations were done by an outside service provider. The bed system evaluation document, provided to

Inspector # 655 on February 17, 2017, by Maintenance Worker #110, included the following statements: "if zones 1-4 pass entrapment testing a passing grade will be issued"; "if any zones between 1-4 fails entrapment testing a failing grade will be issued"; and, "if zones 5, 6 or 7 fails then a passing grade is issued but these zones should be addressed to ensure resident safety".

As a result of the evaluation process, 23 out of 114 bed systems were given a failing grade, as one or more of the potential zones of entrapment with prescribed dimensional limits (zones 1-4) exceeded the prescribed dimensional limits. According to the bed system evaluation document, the recommended solution for 19 of the failed bed systems, from the outside service provider, was to replace the mattress with a specified brand and design of mattress. Other recommended solutions from the outside service provided for the other four bed system failures included: replacement of the bed, switch to a newer style of rail, and tightening of the existing rails. Inspector #655 also noted a hand-written note on the bed-system evaluation document next to six of the failed bed systems (bed #s 10, 59, 61, 75, 103, 112) which read: "Done".

During an interview on February 21, 2017, Environmental Services Manager #125 indicated to Inspector #655 that where "done" is noted next to six of the failed bed systems (bed #s 10, 59, 61, 75, 103, 112), it is indicative that the recommended solution has, as per the bed system evaluation document, had been implemented. That is:
- For bed #10, the mattress would have been replaced and the bed rails tightened,
- For bed #59, the mattress would have been replaced and the bed rails tightened,
- For bed #61, the mattress would have been replaced and the bed rails tightened,
- For bed #75, the mattress would have been replaced and the headboard moved closer,
- For bed #103, the mattress would have been replaced and the headboard moved closer; and,
- For bed #112, the rails would have been tightened.

During the same interview on February 21, 2017, Environmental Services Manager #125 indicated to Inspector #655 that following the changes made to the six noted bed systems, the resulting new bed systems had not been evaluated in accordance with the HC Guidance Document, including the testing of zones 1-4, in order to minimize risk to the residents.

On February 21, 2017, through observation, discussion with Environmental Services Manager #125, and review of the bed system evaluation document, it was established that since the July, 2016 bed system evaluation process, a new bed system had been

created in the specified room belonging to resident #033.

Resident #033, both at the time of the evaluation process and now, was in a bed system (bed #25) that had been given a passing grade, with no identified zone failures. The bed system in room 111-1 was a manual bed and it included a therapeutic air mattress at the time of the bed evaluation process. On February 17, 2017, Inspector #655 observed the bed belonging to resident #033 to be labeled, on the foot board, as bed # 108. On February 21, 2017, Environmental Services Manager #125 observed the same, and noted that resident #033 was now using an electric, as opposed to a manual bed. According to the bed system evaluation document, bed #108 did not have an air mattress on it at the time of the bed system evaluation in July, 2016. Environmental Services Manager #125 indicated that some time after the July, 2016 bed system evaluations, bed #108 was moved in a specific room for use by resident #033; and at that time, the existing mattress on bed #108 would have been replaced with a therapeutic air mattress. Environmental Services Manager #125 indicated to Inspector #655 that the resulting new bed system (now bed #108) was not evaluated accordance with the HC Guidance Document, including testing of zones 1-4, in order to minimize risk to the resident.

It was further noted by Inspector #655 on February 17, 2017, that the cone and cylinder tool, which is shared between homes and is required for testing of zones 1-4, was in the home. According to Maintenance Worker #110, the tool had been in the home for a period of at least a week as of February 17, 2017; and possibly longer.

Over the course of the inspection, it was ascertained that where changes were made to a resident's bed system, such as a change of mattress or bed rails, the home did not have a process in place to ensure that the resulting new bed system was evaluated in accordance with evidence based practices, to minimize risk to the resident.

The licensee has failed to ensure that where bed rails are used, 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. [s. 15. (1) (a)]

2. The licensee has failed to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Inspector #655 observed the beds belonging to residents #033, #034, #036 and #040 over the course of the inspection.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #033. At the time of the observation, two ¼ length bed rails were observed to be in the up position; and, from the foot of the bed, the left rail was observed to be loose. At the same time, it was noted that the mattress on resident #033's bed system was a therapeutic air mattress. The DOC/administrator was made aware. The two ¼ length bed rails were observed to remain in the up position over the course of the inspection. On February 21, 2017, the left bed rail was observed to have been tightened.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #034. At the time of the observation, two bed rails were observed to be in the up position. From the foot of the bed, the right rail was a ¼ length rail. On the same day, Inspector #655 observed a gap large enough for the Inspector to fit two hands between the top of the mattress and the head board - the mattress was not fitted against the mattress keepers of resident #034's bed system. On February 21, 2017, the same bed rails were observed to be in the up position. At the time of the second observation, Inspector #655 observed the left rail to be loose. On February 23, 2017, Inspector #655 observed that the gap between the mattress top and headboard remained.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #036. At the time of the observation, two ¼ length bed rails were observed to be in the up position; and, from the foot of the bed, the right rail was observed to be loose, creating a larger gap between the right bed rail and the mattress and bed frame when compared to the left. At the same time, it was noted that the mattress on resident #036's bed system was a therapeutic air mattress. The Administrator/DOC was made aware. On February 21, 2017, Inspector #655 observed the two ¼ length bed rails to again be in the up position. At the time of the second observation, the right rail remained looser when compared to the left. During an interview on the same day, resident #036 indicated to Inspector #655 that his\her bed rails are normally in the up position, and that they had been used this way since the time of his/her admission. Resident #036 was admitted to the home in 2013.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #040. At the time of the observation, two bed rails were observed to be in the up position. From the foot of the bed, there was a ¾ length bed rail on the left side, and a rotation rail on the right side. The right rotation rail was observed to be loose. On the same day, Inspector #655 observed a gap large enough for the Inspector to fit two hands between the top of the mattress and the head board - the mattress was not fitted against the

mattress keepers of resident #040's bed system. On February 21, 2017, both bed rails were again observed to be in the up position. On February 23, 2017, Inspector #655 observed that the gap between the top of the mattress and head board remained.

In August, 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

In July, 2016, 114 bed systems were evaluated in accordance with the methods outlined in the HC guidance document. The bed system evaluations were done by an outside service provider.

During an interview on February 17, 2017, Maintenance Worker #110 provided Inspector #655 with the bed system evaluation document. The bed system evaluation document included the following statements: "if zones 1-4 pass entrapment testing a passing grade will be issued"; "if any zones between 1-4 fails entrapment testing a failing grade will be issued"; and, "if zones 5, 6 or 7 fails then a passing grade is issued but these zones should be addressed to ensure resident safety".

On review of the bed system evaluation document by Inspector #655, it was noted that the bed systems belonging to resident #036 and #040 both received failing grades as a result of the bed system evaluation. As previously noted, both of these bed systems were observed to have loose rails on February 14, 2017; and the bed system belonging to resident #036 was observed to include a therapeutic air mattress.

According to the HC guidance document, Zone 2 is the area under the rail, between the rail supports or next to a single rail support; and Zone 4 is the area under the rail, at the ends of the rail. Factors including mattress compressibility, lateral shift of the mattress or

rail, or any degree of play from loosened rails or rail supports can increase the gap size in Zones 2 and 4. According to the bed system evaluation document, the bed system belonging to resident #036 failed zone 4; while the bed system belonging to resident #040 failed both zones 2 and 4.

As a a result of the evaluation process, 21 additional bed systems (23 total, including those belonging to residents #036 and 040) out of 114 bed systems were given a failing grade, as one or more of the potential zones of entrapment with prescribed dimensional limits (zones 2- 4) exceeded the prescribed dimensional limits. There were no zone 1 failures; and, for two of the 23 failed bed systems, zone 6 also failed.

The recommended solution from the outside service provider for 19 of the 23 failed bed systems was to replace the mattress with one of two specified designs of mattresses of the same brand. Other recommended solutions included: replacement of the bed, tightening of bed rails, and change to a new or different style of rail.

In addition to the 23 bed systems that were given a failing grade, there were 14 additional beds that were given a passing grade despite having one or more zone failures, for a total of 37 bed systems (out of 114 bed systems that were tested) with zone failures.

Of the 14 additional bed systems, five were bed systems that included a therapeutic air mattress at the time of the bed system evaluation in July, 2016. These five bed systems (bed #s 29, 40, 65, 89, 102) were given a passing grade but had one or more zones (zones 2, 3, 4) that failed the dimensional limit testing. On the bed system evaluation document, in the "additional notes" column for these bed systems, a note reads: "LAL (partial exemption)".

In the HC document, such therapeutic air surfaces are exempt from dimensional limit recommendations, except for spaces within the rail (zone 1). It is outlined in the HC guidance document (pages 12 and 13) that this partial exemption is due to the highly compressible nature of these mattresses. As such, there is an inherent risk of entrapment in bed systems using these products with bed rails.

Of the 14 additional bed systems that were given a passing grade but had one or more zone failures, six of them (bed #s11, 41, 45, 48, 72, 105) had zone 7 failures. Zone 7 is the potential zone of entrapment (for the head) between the headboard or foot board and the mattress end, and is indicative of a mattress that does not fit the bed frame.

Bed #105 is the same bed system, belonging to resident #034, that was observed by Inspector #655 on February 14 and again on February 23, 2017, to have a two-hands width gap between the mattress and headboard. According to the bed system evaluation document, dated July, 2016, the recommended solution for bed #105, belonging to resident #034, was to replace the mattress. The additional notes for the same bed system indicated "short mattress". There was no documentation to indicate that the mattress had been changed.

During an interview on February 21, 2017, Environmental Services Manager #125 indicated to Inspector #655 that where there is a hand written note reading "done" next to the bed number on the bed system evaluation document, the recommended solution had been implemented to address the bed system failures. Of the 23 bed systems that received a failing grade, "done" was written next to six of them. There was no note to indicate that the solution had been implemented next to the bed systems belonging to residents #036 or #040. Of the 14 additional bed systems that were given a passing grade, but failed one or more potential zones of entrapment, "done" was written next to four of them. There was no note next to the bed system belonging to resident #034 to indicate that the recommended solution had been implemented.

It was further confirmed, during the same interview with Environmental Services Manager #125 on February 21, 2017, that following the changes that were made to the 10 above-noted bed systems, the resulting new bed systems had not been evaluated in accordance with the HC document, including testing of zones 1-4, as is required by O. Reg. 79/10, s. 15 (1) (a), in order to minimize risk to the residents. Environmental Services Manager #125 acknowledged that an order of new mattresses had been received, but had not yet been implemented. With regards to those bed systems where the recommended solution had not yet been implemented, Environmental Services Manager #125 was unable to speak to any other interventions or modifications that had been made in the interim, in order to prevent risk to the resident. With the exception of 10 bed systems (bed #s 10, 59, 61, 75, 103, 112; and, 29, 79, 104, 110), there had been no corrective actions or interventions implemented to date in relation to the failed potential zones of entrapment identified on a total of 37 bed systems, in order to prevent resident entrapment.

During an interview on February 21, 2017, the Administrator/DOC indicated to Inspector #655 that no other interventions or modifications had been made to the bed systems with

zone failures in order to minimize risk to the resident.

Upon becoming aware that a total of 37 resident's bed systems with bed rails in use were evaluated to have one or more failed potential zones of entrapment in July, 2016, the licensee did not take steps to prevent resident entrapment, taking into consideration the failed potential zones of entrapment.

As the non- compliance described above is widespread, and presents the risk of entrapment, a compliance order will be served on the licensee. [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 O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008 and #038, with weight changes as described by O.Reg 79/10, s.68, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

The health care record of resident #008, describes the resident at nutritional risk related to several diagnosis. The most recent MDS assessment dated on a specific month in 2016, indicates the resident consumes less than 75% at most meals, requires feeding assistance and has weight loss over the last three months. The goal from this assessment was to improve oral intake and maintain a stable weight at a specified range.

The following is the documented weight record for resident #008:
For a specified month, 0.4 kgs above the identified range
For the following month, weight on the identified range
For the following month after, 3.2 kgs below the identified range
For the following month after, 4.4 kgs below the identified range

The weight record demonstrates that in a specified month, the resident had a weight loss of over 7.5% in three months; in another specified month, the resident had a weight loss of over 5% in one month, over 7.5% in three months and over 10% in six months.

In review of the resident's health care record and through interviews with the home's Nutritional Manager and Registered Dietitian, there was no assessment of the resident's weight loss for two specified months. The RD, who was identified as having the responsibility to assess changes weight, indicated that resident #008 was scheduled for a quarterly assessment this month and the weight would be reviewed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The health care record of resident #038 describes the resident at nutritional risk relates to inadequate oral intake, low body weight and need for feeding assistance. The most recent MDS assessment dated on a specified month indicates a specified BMI for the resident which indicates that the resident is severely underweight. The goal at the time of this assessment was to prevent further weight loss and achieve a body weight within a specified range.

The resident's documented weight record is as follows:
For a specified month, 5.5 kgs below the identified range
For the following month, 8 kgs below the identified range
For the following month after, 8 kgs below the identified range

The weight record indicates a weight loss in a specified month of over 10% in six months.

In review of the health care record and discussions with the home's Nutritional Manager and Registered Dietitian, it was determined that a specified month, weight was not entered into Medecare; the electronic health care record used to produce weight reports each month. Rather the specified month weight was only accessible on the hard copy

bath sheets used by PSWs to record resident weights. As described by the NM and RD, the weight loss of resident #038 was not assessed as the weight was not available in Medecare.

Resident #008 and #038 did not have an assessment of weight loss completed, nor were actions taken and outcomes are evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents identified with weight changes will be assessed and that actions will be taken and outcomes evaluated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

On February 14, 2017, Inspector #655 observed resident #044 to have slid down in his/her wheelchair. At the time of the observation, Inspector #655 observed that resident #044 was wearing a safety device, which was positioned around a specific body part. RN #115 was made aware, at which time resident #044 was transferred back to bed.

During interviews on February 22, 2017, PSW #130 and PSW #131 indicated to Inspector #655 that resident #044 requires a safety device when using a wheelchair because resident #044 tends to slide out of his/her wheelchair.

On the same day, PSW #130 indicated to Inspector #655 that resident #044 has difficulty sitting up straight, and would not have the strength to remove the safety device on his/her own. PSW #130 further indicated that it would be unsurprising if resident #044 slid out of his/her wheelchair, even with the safety device in place.

During an interview on February 22, 2017, RN #115 indicated to Inspector #655 that resident #044 is monitored by staff (i.e. PSWs) on an hourly basis when seated in the wheelchair with a safety device in place; and that registered staff would reassess the resident and effectiveness of the restraint if/when there is a change observed. RN #115 indicated to Inspector #655 that the hourly checks are documented on the residents' "Restraint/PASD Monitoring Form" located in the Restraint Binder. RN #115 indicated to Inspector #655 that it is the registered staffs' responsibility to initiate the "Restraint/PASD Monitoring Form", but that this form was otherwise not being used by registered staff.

On review of resident #044s' health care record, Inspector #655 was unable to locate any documentation to demonstrate that the residents' condition and effectiveness of the seat belt restraint had been reassessed at least every eight hours by a physician, registered nurse in the extended class, or member of the registered nursing staff.

During an interview on February 22, 2016, the DOC/Administrator indicated to Inspector #655 that registered staff are expected to reassess the residents condition and effectiveness of the restraint every eight hours, and that the reassessment is to be documented on the "Restraint/PASD Monitoring Form", under "Re Assess".

On the "Restraint/PASD Monitoring Form" reviewed by Inspector #655 and RN #115 on February 22, 2017, there was no documentation in the space labeled "Re Assess" to indicate that a registered staff member had reassessed resident #044s condition or effectiveness of the safety device restraint on February 14, 2017 - the same day that resident #044 was found to be sliding out of his/her chair, with the safety device

positioned around a specific body part. Moreover, there was no documentation in the space labeled "Re Assess" to indicate that a registered staff member had assessed the residents' condition or effectiveness of the seat belt restraint on any day or shift over a one month period with the exception of three specified shift.

Inspector #655 reviewed the North Restraint Binder (for residents residing on specific home areas) and observed "Restraint/PASD Monitoring Forms" dated February, 2017, for eleven additional residents who use restraints and/or PASDs (i.e. seat belts, tilted wheelchairs, table tops, or bed rails). In all cases, there was no documentation to indicate that any of the resident's conditions had been reassessed or the effectiveness of the restraining devices evaluated by a member of the registered nursing staff, at least every eight hours.

The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances. [s. 110. (2) 6.]

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 at least every eight hours, resident #044's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class or a member of the registered nursing staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

This finding is related to Log #030184-16 in relation with resident #048.

The home submitted a Critical Incident Report to the Director under LTCHA on a specified date in October 2016, for an adverse medication incident.

In a review of resident #048's progress notes dated on specified date in October 2016 by Inspector #592, it is indicated that resident #048 was sitting at the breakfast table and was provided a prescribed beverage by a PSW which contained crushed medications prescribed for resident #049. The progress notes further indicated that the PSW noticed the presence of altered medications in the bottom of the cup and reported the incident to the RPN in charge. The progress notes further indicated that resident #048's was assessed by the RPN and that the physician was contacted and an order was given to send resident #048 to the hospital.

In a review of the Hospital Record dated on the day of the incident, it is indicated under diagnosis: Specified complications related to the medication incident . It is also indicated that resident #048 had received specific interventions as a medical intervention related to this complication.

In a review of the Medication Administration Records for resident #048, it was documented that the resident was administered nine prescribed medications on the day of the incident at 0800 hours as part of his/her regular drug regimen.

In a review of the home's description of the Critical Incident and the home's Medication Administration Records, it was documented that resident #048 had received 10 additional medications at breakfast time intended for resident #049.

On February 23, 2017, during an interview with RPN #105, involved in the incident, she indicated to the Inspector that all the medications prescribed for resident #049 were crushed and mix into the prescribed beverage that morning and were left on the breakfast table in front of resident #049. She further indicated that usually she is monitoring the resident from the dining entrance door but that morning she was caught up with emergencies therefore did not monitor the intake of the prescribed beverage for

resident #049. She further indicated that the PSW brought the incident to her attention about giving the prescribed beverage to resident #048 which she thought was his/her's until some altered medications were observed in the bottom of the glass. She further told Inspector that it was reported to the RN who took over the situation.

On February 23, 2017, during an interview with the Administrator, she indicated to the Inspector that following the incident, education was provided to the registered staff member and that the practice of adding medications to the Resource beverage was stopped. [s. 131. (1)]

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 the drug administrated to a resident has been prescribed for the resident, to be implemented voluntarily.

WN #5: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

The most recent MDS assessment dated January 2017, describes resident #013 as requiring total assistance for all activities of daily living, that the resident is no longer able to participate with care, is wheelchair dependent and non-ambulatory. Interviews with the resident's family member, two regular PSW staff members and the regular day RPN, describe the resident as non-verbal, non-weight bearing and dependent in wheelchair and unable to participate in care or decision making.

The current plan of care indicates that the resident can be cued to wash his/her face and hands, is to be reminded to use his/her call bell when he/she need to use the bathroom and to offer to walk the resident to and from the bathroom, the resident will choose clothing each day and staff will offer the choice of shower or bath.

The plan of care is not based on the needs and most recent assessment of resident #013. [s. 6. (2)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care for resident #047 and #050, are documented.

This finding is related to Log #025150-16 and #025822-16.

A critical incident report was submitted to the Director, describing that resident #047 had gone missing on a specified date in August 2016. The resident was found and brought back to the home without injury.

Inspector #148 reviewed the resident's health care record and spoke with PSW #128 and RPN #103, who both indicated that the resident frequently wanders the home but is less active in recent months to exit seek. In speaking with the home's Administrator, the resident was described as exhibiting increased exit seeking behaviours during summer months.

The current plan of care, and the plan of care in place at the time of the incident, indicate that the resident has both wandering and exit seeking behaviours and that staff are to monitor and record his/her whereabouts hourly (otherwise known as security checks). When asked, PSW #128 reported that security checks for resident #047 are completed every hour. The documentation of the August 2016 security checks were unable to be located in the resident's health care record.

The documentation of the January and February 2017 security checks were reviewed by

the Inspector, both monthly records indicate that security checks are completed every two hours. It was demonstrated that in January 2017, there were 31 days whereby the security check documentation is incomplete, for one or more entries. It was demonstrated that between February 1-23, 2017, there are 23 days whereby security check documentation is incomplete, for one or more entries.

A critical incident report was submitted to the Director, describing that resident #050 had been involved in an alleged sexual abuse with a co-resident on a specified date in August 2016.
In response to the incident the resident was placed on hourly security checks on specific time of the days, based on the time of day of the incident. Inspector #148 reviewed the August 2016 Wanders Location within the home (otherwise known as security checks) which demonstrated that between August 19-31, 2016, there were 12 days whereby the security check documentation was incomplete for one or more entries.

Inspector #148 reviewed the resident's health care record and spoke with PSW #122 and #132, who both indicated that the resident continues on hourly security checks. The current plan of care for this resident describes the need to monitor the resident between specific time of the days to prevent any inappropriate situations. PSW #132 described the resident as still exhibiting socially inappropriate behaviours at times. The documentation of the January and February 2017 security checks were reviewed by the Inspector. It was demonstrated that in January 2017, there were 31 days whereby the security check documentation is incomplete, for one or more entries. It was demonstrated that between February 1-23, 2017, there are 23 days whereby security check documentation is incomplete, for one or more entries.

The documentation of security checks for resident #047 and #050 is not complete as it relates to the provision of care set out in the plan of care for hourly security checks. [s. 6. (9) 1.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 15 (2) (a) in that the licensee did not ensure that the home's furnishings and equipment are kept clean and sanitary.

During the Inspection, Inspectors #543 and #148 observed that two residents mobility equipment was soiled.

On February 14, 2017, resident #008's wheelchair frame was observed by Inspector #148 with debris on metal area of seat and observed also the safety device with heavy debris imbedded in the material.
On February 14, 2017, resident #019's wheelchair was observed by Inspector # 543 with unidentified debris and stain on the right side of the seating cushion and on the right brake.

As a result, Inspector #592 further inspected the ambulation equipment for the two residents on February 17, 2017:
• Resident #008's wheelchair frame was observed with debris on the metal area of seat and heavy debris with white matter was also observed on the resident's lap belt.
• Resident #019's wheelchair frame was observed with unidentified debris located on the right brake and debris on the right side of the seating cushion.

On February 17, 2017, during an interview with PSW #108, she indicated to the Inspector that it was the responsibility of the night PSW staff to clean resident's ambulation equipment with a disinfecting product. She further indicated to inspector #592 that in the meantime, if the staff observed soiled resident's equipment, they will notify the Life

Enrichment Coordinator who will clean them. PSW #108 further indicated to Inspector #592 that there was a specific binder located at the nurses desk with specific night duties assignment and showed to the Inspector the sheet titled "South End" which indicated when to clean the ambulating equipment.

It is to be noted that resident #008 resides on a specific unit.
In a review of the specific unit sheet, it was indicated that all residents wheelchair and walkers located on the specified unit were to be washed weekly on a specific day. The sheet further indicated that two staff members have put their initials on that specific day under washing chairs, wheelchairs, walkers and comfy chairs for resident #008.

It is to be noted that resident #019 resides on a specified unit.
In a review of the specific unit sheet it was indicated that all residents wheelchair and walkers located on that specified unit were to be washed weekly on a specific day. The sheet further indicated that two staff members have put their initials on that specific day under washing chairs, wheelchairs, walkers and comfy chairs for resident #019.

On February 17, 2017, during an interview with RPN #103, she indicated to the Inspector that when a task was completed, PSW are to document beside the task, by recording their initials on the form. She further indicated that the night assignment sheet was signed on February 16, 2017, therefore resident's #019 wheelchair was expected to be cleaned. Inspector #592 showed RPN #103 the resident's #019 wheelchair. RPN #103 indicated that the chair was dirty and that it was not acceptable.

On February 21, 2017, during an interview with the Life Enrichment Coordinator, she indicated to the Inspector that the resident mobility equipment is cleaned by the night PSW staff following the assignment sheet for night shift. She further indicated that she was doing weekly audits as well and leaving notes to PSW for specific resident's mobility equipment that needed deep clean and were noted to be soiled. She further indicated to the Inspector that resident #019 and #008 mobility equipment was identified several weeks ago to be soiled and needed to be cleaned. She further indicated to the Inspector that it was not acceptable as she already left instructions to staff members several weeks ago and was expecting that the mobility equipment was kept clean and sanitary for resident #019 and #008. [s. 15. (2) (a)]

2. The licensee has failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The home has a resident-staff communication and response system at each resident's bedside. The communication system consists of a wall panel whereby there is a reset switch and a plug for the call bell cord. At the end of the call bell cord is a red button. The communication system is activated by pressing the red button or pulling out the call bell cord.

During room observations on February 14, 2017, Inspector #148 identified two communication systems not functioning properly. In a specific room at the bedside of resident #001. The Inspector was unable to activate the communication system by pushing the red button; activation was successful when the call bell cord was pulled from the wall panel.

In another specific room at the bedside of resident #008 and resident #046, there is a shared wall panel between beds 3 and 4. The Inspector was unable to activate the communication system by pushing the red button or by pulling the call bell cord out of the wall. The inspector then toggled the reset switch, after doing so the communication system was activated by pushing the red button. However, when deactivated by toggle of the reset switch, a second attempt to activate the communication system was unsuccessful by both pushing of the red button and pulling the cord from the wall. Resident #046 was able to speak to the function of the communication system, the resident described that the red button had not been working properly for about two weeks noting that when he/she used the system during the evenings nothing would happen. Evening PSW #123, indicated that she had noticed the call bell in that specific room to not always work and was needing to pull the call bell cord from the wall several times before the call would activate. PSW #123 had not brought the malfunction forward to the maintenance communication book.

The Inspector made the home's Administrator aware of the malfunctioning call bells. On February 15, 2017, the Inspector spoke with maintenance staff member #110. He indicated that the call bell cord for resident #001 was not functioning properly and required replacement. He indicated that the communication system in that specific room was malfunctioning due to the reset switch "sticking", and it was the reset switch that required replacement. He described that when a call is deactivated from this point, the reset switch was not returning to a neutral position, therefore, the system was not able to register any subsequent attempt at activation. He noted that the panel would be repaired on February 16, 2017.

When asked by the Inspector, staff member #110, indicated that he had no knowledge of

a dysfunction in the communication system for either room 201 or 206 prior to the notification provided by the Inspector.

The home did not ensure that the resident-staff communication and response system, in rooms 201 and 206, were in a state of good repair. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

On a specified date in August 2016, a Critical Incident report was submitted to the Director describing an incident of alleged sexual abuse between residents #050 and #051.

This finding is related to Log #025822-16.

The home's Administrator indicated to Inspector #148, that she was aware of the incident on the day it occurred, through the home's internal reporting process for after hours. She described that she was not in the home and had begun to complete the report to the Director off-site; the report was submitted to the Director when she returned onsite to the home.

The report of alleged sexual abuse between residents #050 and #051 was not reported immediately to the Director. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #013 is bathed, at a minimum twice a week by the method of his or her choice.

Inspector #148 spoke with a SDM for care for resident #013. The SDM indicated that resident #013 is provided with bathing twice a week and prefers the provision of tub baths. The flow sheets for February 2017, indicate that the resident was provided with tub bath on 3 occasions and provided with a bed bath on 3 occasions as well. The Inspector spoke with the regular day PSW #112 who indicated that the resident requires total assistance for bathing and two person assist for transfers. PSW #112 indicated that the resident's preference has been tub baths, but noted that at times, the resident is provided a bed bath due to a lack of staff available to provide the tub bath.

Resident #013 was not provided with bathing twice a week by his/her preferred method of tub bath, in February 2017. [s. 33. (1)]

2. The licensee has failed to ensure that resident #006 is bathed, at a minimum twice a week by the method of his or her choice.

This finding is related to Log #00487917.

On February 23, 2017, Inspector #592 spoke with resident #006 and the resident's SDM for care, both indicated that bathing is not provided to the resident twice weekly, specifically noting that the evening bathing for this past Tuesday was missed. The flow sheets for February 1-22, 2017, were reviewed by Inspector #148. The flow sheets indicate that the provision of bathing was documented on February 11 and 19, there is no documentation to support the provision of two baths per week in February 2017. Inspector #148 spoke with PSW #137, who indicated that baths are not always provided on evenings as staff are not always available for this task.

Resident #006 was not provided with bathing twice a week, in February 2017.

The home's Administrator indicated that plans are underway to re-organize PSW staff to accommodate the provision of bathing in the home. [s. 33. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that a response in writing is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On February 16, 2017, during an interview, Inspector #573 spoke with the Residents' Council president who indicated that he/she was unsure if the licensee responds in writing within 10 days with regards to any concerns or recommendations from the Residents' council.

Inspector #573 reviewed September 2016 and January 2017 minutes of the Residents' Council meetings. It was observed by the Inspector that the licensee responded in writing with regards to the concerns/ recommendations from the Resident's council but not within 10 days.

- September 20, 2016 - meeting concerns regarding staff infection control practices in the dining room (Hand washing) and issues related to PSW staff members not introducing themselves to the residents when entering in the resident room, the written response date was October 20, 2016.

- January 17, 2017 - meeting concerns regarding all residents are not invited to the activity programs and recommendations for more strenuous exercises the written response date was February 02, 2017.

The Life Enrichment Coordinator, who was assigned to assist the Residents' Council, indicated to the Inspector #573 that any concerns or recommendations from the Residents' Council are documented on the day of meeting and sent to the appropriate department managers. The Life Enrichment Manager indicated that the concerned department manager will provide a written response within 10 days. Further she indicated that once she received all the written response, she will prepare the meeting minutes with the written response and present to the president of the resident council.

On February 16, 2017, Inspector #573 reviewed Residents' Council meeting minutes for September 2016 and January 2017 with the Life Enrichment Coordinator, who indicated that a written response with regards to concerns and recommendations to the Council was not provided within 10 days. [s. 57. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that where a medication incident or adverse drug reaction in respect of which the resident is taken to hospital, to inform the Director of the incident no later than one business day after the occurrence of the incident.

This finding is related to log #030184-16, involving resident #048.

The home submitted a Critical Incident Report to the Director under LTCHA on a specified date in October 2016, for an incident that occurred seven days before.

The Critical Incident Report indicated that resident #048 was sitting at the breakfast table and was provided with a prescribed beverage by a PSW which contained crushed medications prescribed for resident #049. The progress notes further indicated that the PSW noticed the presence of altered medications in the bottom of the cup and reported the incident to the RPN in charge. The progress notes further indicated that resident #048 was assess by the RPN and the physician was contacted and an order was given to send resident #048 to the hospital.

In a review of the Hospital Record dated on the day of the incident, it is indicated under diagnosis: Specified complications related to medication incident. It is also indicated that resident #048 had received specific treatments as a medical intervention for this complication.

In a review of resident #048's progress notes dated on the day after the incident , it is indicated that resident #048 vital signs had reached their normal reading, therefore resident #048 was send back to the home.

On February 23, 2016, during an interview with the Administrator, she indicated to the Inspector that at the time of the incident she was the person responsible to complete the Critical Incident Forms. She further indicated upon asking about the time frame of the submitted report, that she has sent the Critical Incident within the expected time frame and provided to the Inspector a copy of the Critical Incident form indicated that the form was saved four days after the incident. However, the form was not submitted by the Administrator to the Director until seven days after the incident. [s. 107. (3)]

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

Issued on this 16th day of March, 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) :	MELANIE SARRAZIN (592), AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), MICHELLE JONES (655)
Inspection No. / No de l'inspection :	2017_548592_0006
Log No. / Registre no:	003066-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 16, 2017
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	WOODLAND VILLA 30 Milles Roches Road, R. R. #1, Long Sault, ON, K0C-1P0
	Janice Sabourin

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 Administrator /
Nom de l'administratrice
ou de l'administrateur :

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, 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)

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 is ordered to:

1. Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment. The interventions identified in the HC Guidance Document companion document, "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (U.S. FDA June, 2006), shall be considered for each resident and their bed system, including those bed systems with a therapeutic surface such as low air loss mattresses (LAL). This will be done using an individualized, systematic and documented approach. These actions must be completed within 14 days of this order being served.

2. Where bed rails are used, evaluate any bed systems that were modified after the July, 2016, bed system evaluation, in accordance with evidence-based practices in order to minimize risk to the resident. Where it is unknown whether the bed system was or was not modified after the July, 2016, bed system evaluation, evaluate the bed system. This must be completed within 14 days of this order being served.

3. Establish and implement a process for ensuring that all future bed system

failures, are addressed immediately by taking the necessary corrective actions in accordance with the HC companion document titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (U.S. FDA June, 2006).

4. Ensure that the outcomes of bed system evaluations, including those conducted internally and those conducted by external providers, are communicated to staff, specifically the individual(s) responsible for correcting the identified bed system failures.

5. Amend the home's existing "Side-Rail Use Assessment Form" in accordance with the prevailing practices outlined in "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S.F.D.A, April 2003), a companion document to the Health Canada Guidance Document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC Guidance Document). The amended form shall formally capture a risk-benefit analysis related to the use of bed rails for each resident and shall, at a minimum, include questions that can be answered by an interdisciplinary team of assessors related to:

a) the residents' sleep habits, patterns of sleep, level of comfort in bed, behaviours and other relevant factors prior to the application of any bed rails; and,
b) the alternatives that were trialed prior to using one or more bed rails, and the effectiveness of those alternatives during a specified observation period.

6. Reassess all residents for the use of bed rails, at a minimum, whenever there is a change in the resident's physical condition, as recommended in the HC Guidance Document. Update the written plan of care based on the resident assessment for all residents where bed rails are used. Provide clear directions (type of rail, for example) and include in the written plan of care any necessary accessories or interventions that are required to mitigate any identified bed safety hazards.

7. Update the existing policy, #CS-18.12, titled "Bed Rails", dated January, 2011; or, create a new policy that addresses the procedural considerations in assessing residents for the use of bed rails, in accordance with the document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in

Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003).

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident has been 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 August 21, 2012, a letter was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the letter, it is written that this HC Guidance document is expected to be used by Long-Term Care Homes "as a best practice document" for assessig residents and evaluating bed systems. The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States.

The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including the resident's medical needs, sleep habits and patterns, sleep environment, resident comfort in bed, and potential safety risks posed by using one or more bed rails.

The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Inspector #655 observed the beds belonging to residents #033, #034, #036 and #040 over the course of the inspection.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #033. At the time of the observation, two ¼ length bed rails were observed to be in the up position.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #034. At the time of the observation, two bed rails were observed to be in the up position. From the foot of the bed, the left rail was 1/4 length positioned in a vertical position; and the right rail was a ¼ length rail. On February 21, 2017, the same bed rails were observed to be in the up position.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #036. At the time of the observation, two ¼ length bed rails were observed to be in the up position. On February 21, 2017, Inspector #655 observed the two ¼ length bed rails to again be in the up position. During an interview on the same day, resident #036 indicated to Inspector #655 that his/her bed rails are normally in the up position, and that they had been used this way since the time of his/her admission. Resident #036 was admitted to the home in 2013.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #040. At the time of the observation, two bed rails were observed to be in the up position. From the foot of the bed, there was a ¾ length bed rail on the left side, and an assist rail on the right side. On February 21, 2017, both bed rails were again observed to be in the up position.

Inspector #655 reviewed the health care records of residents' #033, #034, #036 and #040, and located a "Side-Rail Use Assessment Form" for each resident. The side-rail use assessment forms for three out of four residents (resident #s 034, 036, 040) were observed by Inspector #655 to be incomplete in that one or more of the following data were missing: alternative interventions, rationale for

the use of bed rails, recommendation for the type of bed rail to be used, signatures. All three forms were dated April, 2016.

During an interview on February 16, 2017, RPN #103 indicated to Inspector #655 that the side-rail use assessment forms are completed for each resident at the time of the residents' admission.

On February 17, 2016, Inspector #655 reviewed the side-rail use assessment form for resident #034, who was admitted to the home in 2016, with RPN #103. RPN# 103 was, at the time of the interview, responsible for completing the admission processes for new resident admissions to the home. The side-rail use assessment form for resident #034 was also dated April 2016. RPN #103 indicated to Inspector #655 that the side-rail use assessment form that had been filled in for resident #034 was considered incomplete, in that all yes/no questions on the form are expected to be answered; and in this case, they were not. Both RPN #103 and Inspector #655 reviewed the second page of the side-rail use assessment form, which was also incomplete in that there was no recommendation made for the type of bed rail to be used, and no signatures. RPN #103 indicated to Inspector #655 that when she uses the side-rail use assessment form, she does not complete page two. RPN #103 explained that the staff refrain from making a recommendation for the type of bed rail to be used for residents due to a lack of expertise related to bed rail type; and indicated that instead, staff would defer to the residents and/or family's request in determining what type of bed rail to use.

During an interview on February 17, 2017, the DOC/Administrator indicated to Inspector #655 that the "Side-Rail Use Assessment Form" – the same form that was observed to be incomplete for all three of the above mentioned residents who currently use bed rails, was intended to be used to assess both the residents need for the bed rail and the residents' safety in using a bed rail (s).

On review by Inspector #655 on February 23, 2017, it was found that the "Side-Rail Use Assessment Form" currently in use by the licensee was not fully in accordance with the prevailing practices identified in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S.FDA, 2003), a companion to the HC Guidance Document. The current "Side-Rail Use Assessment Form", for example, did not address such factors as the residents sleep patterns or habits, the residents' sleep environment or level of comfort in bed. In addition, no clear

documentation of a risk-benefit analysis was observed on the side-rail use assessment forms or elsewhere in the healthcare records of resident #s 033, 034, 036 or 040. During an interview on February 23, 2017, the DOC/Administrator acknowledged the same. At the same time, the DOC/Administrator acknowledged that the current "Side-Rail Use Assessment Form" was implemented in April, 2016 and was the most current one; and prior to that time, residents - such as resident #036 who was using bed rails since his/her admission in 2013 - were not necessarily assessed for bed rail use before bed rails were implemented. The Administrator provided to the Inspector a copy of the policy titled "Bed Rails" (CS-18.12), dated January, 2011. At that the Administrator indicated that this was the most recent policy used at the home.

Inspector #655 reviewed the policy. In the policy, it is stated: "each resident shall be assessed individually to determine the need for their bed rails to be up". The policy did not reference the side rail use assessment form currently in use at the home; nor did it speak to the process of performing and documenting a risk-benefit analysis as it relates to each residents' use of bed rails.

In summary, residents, including resident #s 033, 034, 036, and 040, were not assessed for the use of bed rails in accordance with prevailing practices to minimize risk to the resident.

In addition to providing guidance in establishing a clinical assessment where bed rails are used, the HC Guidance Document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools (the cone and cylinder tool) and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

A total of 114 bed systems in the home were evaluated in accordance with the methods outlined in the HC Guidance Document in July, 2016. The bed system evaluations were done by an outside service provider. The bed system evaluation document, provided to Inspector # 655 on February 17, 2017, by Maintenance Worker #110, included the following statements: "if zones 1-4 pass entrapment testing a passing grade will be issued"; "if any zones between 1-4 fails entrapment testing a failing grade will be issued"; and, "if zones 5, 6 or 7

fails then a passing grade is issued but these zones should be addressed to ensure resident safety".

As a result of the evaluation process, 23 out of 114 bed systems were given a failing grade, as one or more of the potential zones of entrapment with prescribed dimensional limits (zones 1-4) exceeded the prescribed dimensional limits. According to the bed system evaluation document, the recommended solution for 19 of the failed bed systems, from the outside service provider, was to replace the mattress with a specified brand and design of mattress. Other recommended solutions from the outside service provided for the other four bed system failures included: replacement of the bed, switch to a newer style of rail, and tightening of the existing rails. Inspector #655 also noted a hand-written note on the bed-system evaluation document next to six of the failed bed systems (bed #s 10, 59, 61, 75, 103, 112) which read: "Done".

During an interview on February 21, 2017, Environmental Services Manager #125 indicated to Inspector #655 that where "done" is noted next to six of the failed bed systems (bed #s 10, 59, 61, 75, 103, 112), it is indicative that the recommended solution has, as per the bed system evaluation document, had been implemented. That is:
- For bed #10, the mattress would have been replaced and the bed rails tightened,
- For bed #59, the mattress would have been replaced and the bed rails tightened,
- For bed #61, the mattress would have been replaced and the bed rails tightened,
- For bed #75, the mattress would have been replaced and the headboard moved closer,
- For bed #103, the mattress would have been replaced and the headboard moved closer; and,
- For bed #112, the rails would have been tightened.

During the same interview on February 21, 2017, Environmental Services Manager #125 indicated to Inspector #655 that following the changes made to the six noted bed systems, the resulting new bed systems had not been evaluated in accordance with the HC Guidance Document, including the testing of zones 1-4, in order to minimize risk to the residents.

On February 21, 2017, through observation, discussion with Environmental

Services Manager #125, and review of the bed system evaluation document, it was established that since the July, 2016 bed system evaluation process, a new bed system had been created in the specified room belonging to resident #033.

Resident #033, both at the time of the evaluation process and now, was in a bed system (bed #25) that had been given a passing grade, with no identified zone failures. The bed system in room 111-1 was a manual bed and it included a therapeutic air mattress at the time of the bed evaluation process. On February 17, 2017, Inspector #655 observed the bed belonging to resident #033 to be labeled, on the foot board, as bed # 108. On February 21, 2017, Environmental Services Manager #125 observed the same, and noted that resident #033 was now using an electric, as opposed to a manual bed. According to the bed system evaluation document, bed #108 did not have an air mattress on it at the time of the bed system evaluation in July, 2016. Environmental Services Manager #125 indicated that some time after the July, 2016 bed system evaluations, bed #108 was moved in a specific room for use by resident #033; and at that time, the existing mattress on bed #108 would have been replaced with a therapeutic air mattress. Environmental Services Manager #125 indicated to Inspector #655 that the resulting new bed system (now bed #108) was not evaluated accordance with the HC Guidance Document, including testing of zones 1-4, in order to minimize risk to the resident.

It was further noted by Inspector #655 on February 17, 2017, that the cone and cylinder tool, which is shared between homes and is required for testing of zones 1-4, was in the home. According to Maintenance Worker #110, the tool had been in the home for a period of at least a week as of February 17, 2017; and possibly longer.

Over the course of the inspection, it was ascertained that where changes were made to a resident's bed system, such as a change of mattress or bed rails, the home did not have a process in place to ensure that the resulting new bed system was evaluated in accordance with evidence based practices, to minimize risk to the resident.

The licensee has failed to ensure that where bed rails are used, 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. [s. 15. (1) (a)]

(655)

2. The licensee has failed to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Inspector #655 observed the beds belonging to residents #033, #034, #036 and #040 over the course of the inspection.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #033. At the time of the observation, two ¼ length bed rails were observed to be in the up position; and, from the foot of the bed, the left rail was observed to be loose. At the same time, it was noted that the mattress on resident #033's bed system was a therapeutic air mattress. The DOC/administrator was made aware. The two ¼ length bed rails were observed to remain in the up position over the course of the inspection. On February 21, 2017, the left bed rail was observed to have been tightened.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #034. At the time of the observation, two bed rails were observed to be in the up position. From the foot of the bed, the right rail was a ¼ length rail. On the same day, Inspector #655 observed a gap large enough for the Inspector to fit two hands between the top of the mattress and the head board - the mattress was not fitted against the mattress keepers of resident #034's bed system. On February 21, 2017, the same bed rails were observed to be in the up position. At the time of the second observation, Inspector #655 observed the left rail to be loose. On February 23, 2017, Inspector #655 observed that the gap between the mattress top and headboard remained.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #036. At the time of the observation, two ¼ length bed rails were observed to be in the up position; and, from the foot of the bed, the right rail was observed to be loose, creating a larger gap between the right bed rail and the mattress and bed frame when compared to the left. At the same time, it was noted that the mattress on resident #036's bed system was a therapeutic air mattress. The Administrator/DOC was made aware. On February 21, 2017, Inspector #655 observed the two ¼ length bed rails to again be in the up position. At the time of the second observation, the right rail remained looser when compared to the left. During an interview on the same day, resident #036 indicated to Inspector #655 that his\her bed rails are normally in the up position,

and that they had been used this way since the time of his/her admission. Resident #036 was admitted to the home in 2013.

On February 14, 2017, Inspector #655 observed the bed system belonging to resident #040. At the time of the observation, two bed rails were observed to be in the up position. From the foot of the bed, there was a ¾ length bed rail on the left side, and a rotation rail on the right side. The right rotation rail was observed to be loose. On the same day, Inspector #655 observed a gap large enough for the Inspector to fit two hands between the top of the mattress and the head board - the mattress was not fitted against the mattress keepers of resident #040's bed system. On February 21, 2017, both bed rails were again observed to be in the up position. On February 23, 2017, Inspector #655 observed that the gap between the top of the mattress and head board remained.

In August, 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

In July, 2016, 114 bed systems were evaluated in accordance with the methods outlined in the HC guidance document. The bed system evaluations were done by an outside service provider.

During an interview on February 17, 2017, Maintenance Worker #110 provided Inspector #655 with the bed system evaluation document. The bed system evaluation document included the following statements: "if zones 1-4 pass entrapment testing a passing grade will be issued"; "if any zones between 1-4 fails entrapment testing a failing grade will be issued"; and, "if zones 5, 6 or 7 fails then a passing grade is issued but these zones should be addressed to

ensure resident safety".

On review of the bed system evaluation document by Inspector #655, it was noted that the bed systems belonging to resident #036 and #040 both received failing grades as a result of the bed system evaluation. As previously noted, both of these bed systems were observed to have loose rails on February 14, 2017; and the bed system belonging to resident #036 was observed to include a therapeutic air mattress.

According to the HC guidance document, Zone 2 is the area under the rail, between the rail supports or next to a single rail support; and Zone 4 is the area under the rail, at the ends of the rail. Factors including mattress compressibility, lateral shift of the mattress or rail, or any degree of play from loosened rails or rail supports can increase the gap size in Zones 2 and 4. According to the bed system evaluation document, the bed system belonging to resident #036 failed zone 4; while the bed system belonging to resident #040 failed both zones 2 and 4.

As a a result of the evaluation process, 21 additional bed systems (23 total, including those belonging to residents #036 and 040) out of 114 bed systems were given a failing grade, as one or more of the potential zones of entrapment with prescribed dimensional limits (zones 2- 4) exceeded the prescribed dimensional limits. There were no zone 1 failures; and, for two of the 23 failed bed systems, zone 6 also failed.

The recommended solution from the outside service provider for 19 of the 23 failed bed systems was to replace the mattress with one of two specified designs of mattresses of the same brand. Other recommended solutions included: replacement of the bed, tightening of bed rails, and change to a new or different style of rail.

In addition to the 23 bed systems that were given a failing grade, there were 14 additional beds that were given a passing grade despite having one or more zone failures, for a total of 37 bed systems (out of 114 bed systems that were tested) with zone failures.

Of the 14 additional bed systems, five were bed systems that included a therapeutic air mattress at the time of the bed system evaluation in July, 2016. These five bed systems (bed #s 29, 40, 65, 89, 102) were given a passing grade

but had one or more zones (zones 2, 3, 4) that failed the dimensional limit testing. On the bed system evaluation document, in the "additional notes" column for these bed systems, a note reads: "LAL (partial exemption)".

In the HC document, such therapeutic air surfaces are exempt from dimensional limit recommendations, except for spaces within the rail (zone 1). It is outlined in the HC guidance document (pages 12 and 13) that this partial exemption is due to the highly compressible nature of these mattresses. As such, there is an inherent risk of entrapment in bed systems using these products with bed rails.

Of the 14 additional bed systems that were given a passing grade but had one or more zone failures, six of them (bed #s11, 41, 45, 48, 72, 105) had zone 7 failures. Zone 7 is the potential zone of entrapment (for the head) between the headboard or foot board and the mattress end, and is indicative of a mattress that does not fit the bed frame.

Bed #105 is the same bed system, belonging to resident #034, that was observed by Inspector #655 on February 14 and again on February 23, 2017, to have a two-hands width gap between the mattress and headboard. According to the bed system evaluation document, dated July, 2016, the recommended solution for bed #105, belonging to resident #034, was to replace the mattress. The additional notes for the same bed system indicated "short mattress". There was no documentation to indicate that the mattress had been changed.

During an interview on February 21, 2017, Environmental Services Manager #125 indicated to Inspector #655 that where there is a hand written note reading "done" next to the bed number on the bed system evaluation document, the recommended solution had been implemented to address the bed system failures. Of the 23 bed systems that received a failing grade, "done" was written next to six of them. There was no note to indicate that the solution had been implemented next to the bed systems belonging to residents #036 or #040. Of the 14 additional bed systems that were given a passing grade, but failed one or more potential zones of entrapment, "done" was written next to four of them. There was no note next to the bed system belonging to resident #034 to indicate that the recommended solution had been implemented.

It was further confirmed, during the same interview with Environmental Services Manager #125 on February 21, 2017, that following the changes that were made to the 10 above-noted bed systems, the resulting new bed systems had not

been evaluated in accordance with the HC document, including testing of zones 1-4, as is required by O. Reg. 79/10, s. 15 (1) (a), in order to minimize risk to the residents. Environmental Services Manager #125 acknowledged that an order of new mattresses had been received, but had not yet been implemented. With regards to those bed systems where the recommended solution had not yet been implemented, Environmental Services Manager #125 was unable to speak to any other interventions or modifications that had been made in the interim, in order to prevent risk to the resident. With the exception of 10 bed systems (bed #s 10, 59, 61, 75, 103, 112; and, 29, 79, 104, 110), there had been no corrective actions or interventions implemented to date in relation to the failed potential zones of entrapment identified on a total of 37 bed systems, in order to prevent resident entrapment.

During an interview on February 21, 2017, the Administrator/DOC indicated to Inspector #655 that no other interventions or modifications had been made to the bed systems with zone failures in order to minimize risk to the resident.

Upon becoming aware that a total of 37 resident's bed systems with bed rails in use were evaluated to have one or more failed potential zones of entrapment in July, 2016, the licensee did not take steps to prevent resident entrapment, taking into consideration the failed potential zones of entrapment.

As the non- compliance described above is widespread, and presents the risk of entrapment, a compliance order will be served on the licensee. [s. 15. (1) (b)] (655)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 09, 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 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 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 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 16th day of March, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Sarrazin

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