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
Feb 8, 2017	2016_283542_0007	028556-16	Resident Quality Inspection

Licensee/Titulaire de permis

North Shore Health Network
525 Causley Street P.O. Box 970 BLIND RIVER ON P0R 1B0

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

North Shore Health Network - LTC Unit
525 CAUSLEY STREET P. O. BOX 970 BLIND RIVER ON P0R 1B0

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

JENNIFER LAURICELLA (542), LISA MOORE (613)

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): December 5 - 9, 2016.

An additional Log was inspected during this RQI regarding, one Critical Incident report submitted by the home related to sexual abuse.

This inspection addresses both the North Shore Health Network, Long-Term Care Unit #2865 and the ELDCAP Unit #2795.

During the course of the inspection, the inspector(s) spoke with the Long-Term Care Nurse Manager, the Education and Safety Coordinator, Registered Practical Nurses (RPNs), Dietary Manager, Recreation and Rehabilitation Assistant, Personal Support Workers (PSWs), Housekeeping Staff and Behavioural Supports Ontario (BSO), residents and family members.

The Inspectors conducted a walk through of the resident home area and various common areas, made direct observations of the delivery of care and services provided to the residents, observed staff to resident interactions, reviewed resident health care records and various policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **9 WN(s)**
- **5 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 were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

During stage one of the RQI, resident #001, #004 and #007 were identified as requiring additional inspection regarding the use of bed rails.

A) On December 7, 2016, Inspector #613 observed resident #001 in bed with their bed rails in the guard position. A review of their current care plan indicated that the bed rails were to be in the guard position when resident #001 was in bed.

B) Inspector #542 observed resident #004 in bed with their bed rails in the guard position. The current care plan indicated that the resident used the bed rails for bed mobility.

C) Inspector #542 observed resident #007 in bed with their bed rail in the guard position. The current care plan identified that resident #007 used the bed rail for bed mobility.

A record review for the above identified residents was conducted and there were no bed rail assessments completed.

On December 8, 2016, Inspector #542 and #613 interviewed the Nurse Manager, who indicated that the home had not ensured that the residents were assessed with evidence-based practices, when bed rails were used. The Nurse Manager stated that they could implement a resident assessment right now and complete it for all the resident's that utilize bed rails. [s. 15. (1) (a)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #542 completed a health care record review for resident #003. The current care plan identified resident #003 as a nutritional risk. Under the focus heading "Nutritional Risk" the following intervention was documented; the resident was to receive a nutritional supplement with meals.

On December 7, 2016, Inspector #542 interviewed dietary staff #112, who indicated that they used a document titled, "Nourishment List" which guided the staff to know what nourishment each resident was to receive. The nutritional supplement for resident #003 was not on this list.

On a specific day, Inspector #542 observed resident #003 in the dining room at lunch. Resident #003 was not provided with the specific nutritional supplement.

On December 8, 2016, Inspector #542 interviewed the Food Service Manager, who verified that resident #003 had not been provided with the nutritional supplement as ordered by the Registered Dietitian. [s. 6. (7)]

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 plan of care set out in the plan of care was provided to resident #003 as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that was reported was immediately investigated.

On a specific day, Inspector #542 informed the Nurse Manager that resident #004 had stated during an interview with the Inspector that some staff had been rude to them and yelled at them. The resident had stated that some of the staff yell at them. They also stated that some of them speak roughly to them and that they do not like it. Resident #004 was unable to provide any further details.

On December 7, 2016 at 1003 am, Inspector #542 asked the Nurse Manager if they had investigated the incident. They indicated that they had not spoken with resident #004 or conducted an investigation however they would start now. At approximately 1014 am, the Nurse Manager approached Inspector #542 to indicate that they spoke with resident #004. They stated, "I don't think that anything really happened."

On December 8, 2016, the Nurse Manager acknowledged to Inspector #542 that they should have started the investigation on December 5, 2016, immediately after being made aware of the allegation. [s. 23. (1) (a)]

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, a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the implementation of the weight monitoring system to measure and record with the respect to each resident; body mass index and height upon admission and annually thereafter.

On December 6, 2016, during stage one census review, Inspectors #613 and #542 noted that the documentation in Point Click Care (PCC) identified that some resident's heights had not been taken for 2016.

On December 8, 2016, Inspector #613 met with RPN #101 and requested a list identifying all residents' heights for 2016 and a copy of the home's policy on heights. RPN #101 indicated that the home did not have a policy on obtaining annual heights.

The Inspector interviewed PSW #106, who stated that heights were done on admission when the resident arrived to the home and were not done annually on each resident.

RPN #104 provided Inspector #542 with the 2016 height list for all residents and stated, "I know they are supposed to be done annually, but I can guarantee that they have not been done annually." Inspector #542 noted the list was not dated to indicate when the heights were taken and requested RPN #104 to provide a list to identify the dates.

A short time later on the same date, RPN #104 provided two height lists identifying the dates that heights were taken for all residents in LTC and Eldcap beds. The lists were titled, "Current Weights and Vitals".

Inspector #613 reviewed both lists which identified that heights were not being taken annually for each resident. For the Eldcap List, there were 5 out of 10, 50 % of residents who did not have their heights taken in 2016 as follows;

- Resident #003 last done March 21, 2014
- Resdient #010 last done October 30, 2015
- Resident #011 last done October 20, 2015
- Resident #012 last done February 19, 2015
- Resident #013 last done July 7, 2015

For the LTC list, there were 9 out of 22, 40.9 % residents who did not have their heights taken in 2016 as follows;

- Resident #014 last done July 4, 2014
- Resident #015 last done December 30, 2015
- Resident #005 last done June 7, 2012
- Resident #016 last done October 24, 2013

- Resident #017 last done November 11, 2013
- Resident # 018 last done August 30, 2012
- Resident #019 last done June 27, 2014
- Resident #002 last done March 3, 2014

During an interview with RPN # 101, they confirmed that heights had not been done annually on all residents. RPN #101 stated residents heights were taken on admission but were not done annually on each resident. The RPN stated they were unaware of the home's height policy and were unable to locate a height policy. [s. 68. (2) (e) (ii)]

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 nutrition care and hydration program includes; (ii) body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #5: 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 residents were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated for the following weight changes; a change of five per cent of body weight, or more, over one month; a change of seven and a half per cent of body weight, or more, over three months; a change of 10 per cent of body weight, or more, over six months.

During stage one of the RQI, resident #003 and #007 were identified for a weight change which required further inspection.

A) Inspector #542 completed a health care record review for resident #003. The current care plan identified the resident as a nutritional risk. The weight record was reviewed and it was documented that over a period of 9 months, resident #003 had a substantial weight change. It was also documented on the weight record that resident #003 had a 10 percent weight change over a six month period. Resident #003 also had a seven and a half percent weight change, over a three month period. Inspector #542 noted that an assessment had not been completed by the Registered Dietitian (RD) or the Food Service Manager for the two specific months.

B) Inspector #542 completed a health care record review for resident #007. The current care plan identified the resident as a nutritional risk. The weight record was reviewed and it was noted that resident #007 had a five percent weight change over a one month period and a 10 percent weight change over a two month period. Inspector #542 was unable to locate any assessment that had been completed for the weight changes.

On December 8, 2016, Inspector #542 met with the Food Service Manager (FSM). They indicated that generally the staff notify them or the Dietitian when a resident had been noted to have a significant weight change. They also stated that when a resident had a significant weight change, an assessment was to be completed according to the home's policy. The FSM could not locate any completed assessments for the months listed above, for resident #003 and #007.

The Food Service Manager provided a copy of the home's policy titled "Weight Change." Inspector #542 reviewed the policy and noted that a referral was to be made to the RD for residents with unplanned weight loss or inappropriate weight gain. The RD was to then conduct a thorough assessment of the residents that had been referred to them and investigate possible nutrition factors responsible for the weight change. [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 #003, #007 and any other resident 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received retraining annually related to the following: the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections.

On a specific day, Inspector #542 informed the Nurse Manager that resident #004 had stated during an interview with the Inspector that some staff had been rude to them and yelled at them. The resident had stated that some of the staff yell at them. They also stated that some of them speak roughly to them and that they do not like it. Resident #004 was unable to provide any further details.

On December 8, 2016, Inspector #542 interviewed a Housekeeping Staff #103, who indicated that they had never received training on Prevention of Abuse, Neglect and Retaliation in all of the years that they had worked at the home.

Inspector #542 interviewed PSW #106, PSW #107, PSW #108 and PSW #109 and asked if they were aware of what "whistle-blowing protections" meant. All of the staff members where unable to provide an answer.

On December 9, 2016, Inspector #542 interviewed Housekeeping Staff #110. They indicated that they had received training on Prevention of Abuse, Neglect and Retaliation approximately eight years ago.

Inspector #542 interviewed the Education and Safety Coordinator, who was unaware that all staff required retraining on the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections. The Nurse Manager also confirmed that all staff were not provided with the retraining annually related to the above areas. [s. 76. (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 the all staff receive retraining annually related to the Resdients' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections, to be implemented voluntarily.

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 has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; 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.

On a specific day, Inspector #542 informed the Nurse Manager that resident #004 had stated during an interview with the Inspector that some staff had been rude to them and yelled at them. The resident had stated that some of the staff yell at them. They also stated that some of them speak roughly to them and that they do not like it. Resident #004 was unable to provide any further details.

On December 7, 2016 at 1003 am, Inspector #542 asked the Nurse Manager if they had investigated the incident. They indicated that they had not spoken with resident #004 or conducted an investigation however they would start now. At approximately 1014 am, the Nurse Manager approached Inspector #542 to indicate that they spoke with resident #004. They stated, "I don't think that anything really happened." The Nurse Manager submitted the CI report to the Director, two days after the alleged abuse was reported to them.

On December 8, 2016, the Nurse Manager acknowledged to Inspector #542 that they should have reported the abuse on December 5, 2016, immediately after being made aware of the allegation. [s. 24. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure only residents of the long-term care home may be members of the Residents' Council.

On December 7, 2016, Inspector #613 interviewed the President of the Residents' Council, who stated that they did not reside in the Long-Term Care Home.

During interviews with the Assistant to Residents' Council #111 and the Nurse Manager #100, both confirmed that the President of the Residents' Council was not a resident of the long-term care home. [s. 56. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that meal and snack times were reviewed with the Residents' Council.

On December 7, 2016, Inspector #613 reviewed the Residents' Council minutes from January to November 2016 which failed to document that meal and snack times were reviewed with the Residents' Council.

The Inspector interviewed the President and the Assistant to the Residents' Council, both were unsure if the meal and snack times had been reviewed with the Residents' Council.

On December 9, 2016, the Inspector interviewed the Nurse Manager #100, who was unable to confirm or provide documentation to support that the meal and snack times had been reviewed with the Residents' Council. [s. 73. (1) 2.]

Issued on this 9th day of February, 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) :	JENNIFER LAURICELLA (542), LISA MOORE (613)
Inspection No. / No de l'inspection :	2016_283542_0007
Log No. / Registre no:	028556-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 8, 2017
Licensee / Titulaire de permis :	North Shore Health Network 525 Causley Street, P.O. Box 970, BLIND RIVER, ON, P0R-1B0
LTC Home / Foyer de SLD :	North Shore Health Network - LTC Unit 525 CAUSLEY STREET, P. O. BOX970, BLIND RIVER, ON, P0R-1B0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	GASTON LAVIGNE

To North Shore Health Network, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that where bed rails are used, that 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.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

During stage one of the RQI, resident #001, #004 and #007 were identified as requiring additional inspection regarding the use of bed rails.

A) On December 7, 2016, Inspector #613 observed resident #001 in bed with their bed rails in the guard position. A review of their current care plan indicated that the bed rails were to be in the guard position when resident #001 was in bed.

B) Inspector #542 observed resident #004 in bed with their bed rails in the guard position. The current care plan indicated that the resident used the bed rails for bed mobility.

C) Inspector #542 observed resident #007 in bed with their bed rail in the guard position. The current care plan identified that resident #007 used the bed rail for bed mobility.

A record review for the above identified residents was conducted and there were no bed rail assessments completed.

On December 8, 2016, Inspector #542 and #613 interviewed the Nurse Manager, who indicated that the home had not ensured that the residents were assessed with evidence-based practices, when bed rails were used. The Nurse Manager stated that they could implement a resident assessment right now and complete it for all the resident's that utilize bed rails.

The decision to issue this compliance order (CO) was based on the severity of harm which has the potential for actual harm to the safety and well-being of residents. Although the scope of non-compliance (NC) was identified as a pattern, despite previous NC identified as Voluntary Plan of Correction (VPC) during inspection #2014_281542_0010 and another VPC during inspection 2015_395613_0015, NC continues with this area of the legislation. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 24, 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 8th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Lauricella

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