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**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 29, 2015 | 2015_189120_0001 | H-001022-13/A | Other |

### Licensee/Titulaire de permis

THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA
155 PANIN ROAD BURLINGTON ON L7P 5A6

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

CAMA WOODLANDS NURSING HOME
159 PANIN ROAD BURLINGTON ON L7P 5A6

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

BERNADETTE SUSNIK (120)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct an Other inspection.**

**This inspection was conducted on the following date(s): December 30, 2014**

**An inspection (2014-189120-0039) was previously conducted at St. Olga's Lifecare Centre on June 12, 2014 at which time non compliance was identified with respect to bed safety and an Order was issued. On November 27,2014, the residents were permanently re-located to Cama Woodlands Nursing Home and the follow-up visit was therefore completed at Cama Woodlands Nursing Home on December 30, 2014. The conditions that were laid out in the previous order were not fully met and a new order is being issued. See below for details.**

**During the course of the inspection, the inspector(s) spoke with the acting Director of Care and Environmental Services Supervisor regarding bed safety.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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

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

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

**Findings/Faits saillants :**

1. The licensee did not ensure that the residents were assessed in accordance with prevailing practices to minimize risk to the resident where bed rails were used. Prevailing practices includes but is not limited to a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Drug and Food Administration.

The licensee was previously identified to be non-compliant during an inspection of the residents and their beds on June 12, 2014 while located at St. Olga's Lifecare Centre. An order was issued to the licensee on July 24, 2014 to develop a comprehensive bed safety assessment tool using the above noted document, assess all residents using the bed safety assessment tool, update resident's plan of care to include bed rail use and to educate all health care staff with respect to bed rail use and bed safety entrapment zones. These conditions were not met and are being re-issued.

A) During the inspection on December 30, 2014, three residents who were transferred to the home from St. Olga's Lifecare Centre on November 27, 2014 were randomly selected to determine if they received an assessment and whether any risks related to their beds were being mitigated. The residents who were specifically selected were observed to be in bed with one or more rotating assist bed rails elevated and therefore in use and two were sleeping on a therapeutic air mattress. With the assistance of the acting Director of Care, the resident's electronic and paper form records were reviewed. Two residents had information in their records that bed rails were to be applied for either mobility or repositioning and the third did not have a reason why the rails were to be applied. However, no bed safety assessment forms or documentation could be located as to how and by whom the residents were assessed to determine if bed rails were safe for the particular resident, whether alternatives were trialed and the outcome and whether interventions were needed to mitigate any identified risks.

B) Two residents who were observed to be sleeping on therapeutic air mattresses during the inspection did not have any bolsters or gap fillers between the air mattress and their rotating assist bed rails. One out of the two residents had rail pads applied to the rails, however the pads did not prevent a gap from forming on the side of the air mattress when pressure was applied. Their health care records did not identify that they required specialized accessories to mitigate any entrapment gaps. Both air mattresses were very soft and flexible and inherently had entrapment risks due to their design. [s. 15(1)(a)]

***Additional Required Actions:***

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

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**Issued on this 29th day of January, 2015**

**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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | BERNADETTE SUSNIK (120) |
| **Inspection No. / No de l'inspection :** | 2015_189120_0001 |
| **Log No. / Registre no:** | H-001022-13/A |
| **Type of Inspection / Genre d'inspection:** | Other |
| **Report Date(s) / Date(s) du Rapport :** | Jan 29, 2015 |
| **Licensee / Titulaire de permis :** | THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA<br>155 PANIN ROAD, BURLINGTON, ON, L7P-5A6 |
| **LTC Home / Foyer de SLD :** | CAMA WOODLANDS NURSING HOME<br>159 PANIN ROAD, BURLINGTON, ON, L7P-5A6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | ARLENE LAWLOR |

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

To THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA, 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 shall complete the following:

1. Mitigate any identified entrapment risks for residents residing in a bed system that did not pass entrapment zones 2-4.
2. Develop a comprehensive bed safety assessment tool using the US Federal Drug and Food Administration document as a guide titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
3. Assess all residents using the bed safety assessment tool and document the results and recommendations.
4. Update all resident health care records to include why bed rails are being used, how many and any accessories that are required to mitigate any identified entrapment risks.
5. Educate all health care staff with respect to bed rail use and bed safety entrapment zones.

**Grounds / Motifs :**

1. The licensee did not ensure that the residents were assessed in accordance with prevailing practices to minimize risk to the resident where bed rails were used. Prevailing practices includes but is not limited to a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation

of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Drug and Food Administration.

The licensee was previously identified to be non-compliant during an inspection of the residents and their beds on June 12, 2014 while located at St. Olga's Lifecare Centre. An order was issued to the licensee on July 24, 2014 to develop a comprehensive bed safety assessment tool using the above noted document, assess all residents using the bed safety assessment tool, update resident's plan of care to include bed rail use and to educate all health care staff with respect to bed rail use and bed safety entrapment zones. These conditions were not met and are being re-issued.

A) During the inspection on December 30, 2014, three residents who were transferred to the home from St. Olga's Lifecare Centre on November 27, 2014 were randomly selected to determine if they received an assessment and whether any risks related to their beds were being mitigated. The residents who were specifically selected were observed to be in bed with one or more rotating assist bed rails elevated and therefore in use and two were sleeping on a therapeutic air mattress. With the assistance of the acting Director of Care, the resident's electronic and paper form records were reviewed. Two residents had information in their records that bed rails were to be applied for either mobility or repositioning and the third did not have a reason why the rails were to be applied. However, no bed safety assessment forms or documentation could be located as to how and by whom the residents were assessed to determine if bed rails were safe for the particular resident, whether alternatives were trialed and the outcome and whether interventions were needed to mitigate any identified risks.

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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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 27, 2015

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 29th day of January, 2015**

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

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

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