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

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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 6, 2015	2015_380593_0002	S-000664-15	Resident Quality Inspection

Licensee/Titulaire de permis

ESPANOLA GENERAL HOSPITAL
825 MCKINNON DRIVE ESPANOLA ON P5E 1R4

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

ESPANOLA GENERAL HOSPITAL (2932)
825 MCKINNON DRIVE ESPANOLA ON P5E 1R4

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

GILLIAN CHAMBERLIN (593), FRANCA MCMILLAN (544), TIFFANY BOUCHER (543)

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): January 19th - 23rd and 26th - 27th, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Service Manager, Registered Nursing Staff, Dietary Staff, Activation Staff, Maintenance / Housekeeping Staff, Personal Support Worker's (PSW), Residents and Resident family members.

The inspector(s) also observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident Interactions, observed residents environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **2 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. During an interview with Inspector #593 January 22, 2015; the home's Director Of Care (DOC) advised that there has been no bed system evaluation undertaken internally or externally within the home. Furthermore, they advised that the home does not have a process in place to ensure that all residents with bed rails are assessed or their bed system evaluated. To their knowledge, this has not been undertaken in the home in the past six years.

As such the licensee has failed to ensure 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 the risk to the resident. [s. 15. (1) (a)]

2. During stage 1 of the Resident Quality Inspection, Inspector's #593 and #544 identified numerous bed systems with spaces in Zone 7 with potential for head entrapment at both the headboard and footboard.

According to the Health Canada Guidance Document- Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and other Hazards dated March 17, 2008; Zone 7 is defined as "the space between the inside surface of the headboard or footboard and the end of the mattress". Furthermore, according to this document, this space may present a risk of head entrapment when taking into account the mattress compressibility, any shift of the mattress, and degree of play from a loosened headboard or footboard. Health Canada recognizes this area as a potential for entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions.

The three key body parts at risk for life-threatening entrapment in the seven zones of a hospital bed system discussed in the guidance are the head, neck and chest. International anthropometric data references have been used to determine the relative sizes of these body parts for the population at greatest risk for entrapment and to provide a guide for the dimensional limits that would reduce their risk of entrapment. To reduce the risk of head entrapment, openings in the bed system should not allow the widest part of a small head to be trapped. Health Canada is therefore using a head breadth dimension of 120mm as the basis for its dimensional limit recommendations. The population at greatest risk is defined as "patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement or who get out of bed and walk unsafely without assistance. These patients most often have been frail, elderly or confused".

The Health Canada Guidance Document was sent to all licensees of Ontario August 21, 2012; by the Acting Director of the Ministry of Health and Long-Term Care. It was highlighted that "institutions should verify that replacement mattresses are the correct size for the bed frame" and that "the risk of entrapment of residents in hospital-type beds is of such a critical nature; please ensure that your organization follows the Health Canada recommendations and complies with the regulatory requirements to ensure the safety of residents in your LTC home".

Measurements were undertaken during the course of the inspections of all the bed systems within the home that a potential entrapment concern was observed in Zone 7. There were 24 bed systems in the home where the Zone 7 measurement exceeded the 120mm Health Canada recommendation for preventing head entrapment. It should be noted that all of the mentioned room numbers and corresponding bed systems except for two room's had bed rails in use at the time of the inspection.

The measurements were taken, taking into account shifting of the mattress from one end of the bed to the other as per the Health Canada bed entrapment guidance document. Therefore the maximum space allowed by shifting of the mattress was measured. It should be mentioned however that the compressibility of the mattress was not measured therefore the following measurements have the potential to be greater if measured taking into account the compressibility of the mattress and the weight of a human head.

During an interview with Inspector #593 January 22, 2015; the home's DOC advised that there has been no bed system evaluation undertaken internally or externally within the

home. Furthermore, they advised that the home does not have a process in place to ensure that all residents with bed rails are assessed or their bed system evaluated. To their knowledge, this has not been undertaken in the home in the past six years.

According to the Health Canada Guidance Document Zone 7 may present a risk of head entrapment therefore the bed systems mentioned present potential risk to residents within the home for entrapment in this zone, as frail, elderly and confused residents are at the greatest risk for bed entrapment. Furthermore as no bed system evaluation has been undertaken, further risk may be present which can only be identified when a bed system evaluation is undertaken by a trained provider using the appropriate measuring tools.

As such, the licensee has failed to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 001, 002 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. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. On January 23, 2015; Inspector #543 spoke with the Resident Care Coordinator (RCC) regarding dental assessments being offered on an annual basis to residents in the home. The RCC stated that the home has made several attempts to recruit dental hygienists but have not been able to do so. The Inspector also spoke with the DOC who confirmed that the home does not offer annual dental assessments to the residents, and they have not been able to hire any hygienists to perform these assessments. The DOC also confirmed that annual assessments are left to the responsibility of the resident and/or their families.

As such, the licensee has failed to ensure each resident is offered an annual dental assessment and other preventive dental services. [s. 34. (1) (c)]

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 ensuring that all residents within the home are offered a dental assessment on an annual basis and provide the resources for the dental assessment should this be required., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Inspector #544 identified that Resident #015 sustained several falls since their admission in 2014.

Inspector #544 could not find any documentation of any injuries Resident #015 may have sustained as a result of the numerous falls.

Inspector #544 identified that Resident #016 sustained two falls within the last three months. Inspector #544 could not find any documentation of any injuries Resident #016 may have sustained as a result of these falls.

During an interview with the RCC and staff members #104 and #105, they confirmed that the home does not conduct post fall assessments using a clinically appropriate assessment instrument that is specifically designed for falls.

Inspector # 544 reviewed the home's Policy Safety: Falls Prevention and Management, last reviewed in November 2011. The policy did not address the need to conduct a post falls assessment using a clinically appropriate assessment instrument that is specifically designed for falls. The policy did not address that a post fall assessment was to be conducted. The policy only stated, " The RPN will complete a falls risk assessment, document the fall in the progress notes and complete an incident report."

This was confirmed by the RCC and staff members #104 and #105.

The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

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 ensuring that a clinically appropriate assessment instrument specifically designed for post falls assessment is used for all residents should a fall occur., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. Inspector #544 identified January 22, 2015; that Two Cal nutritional supplement, in the medication refrigerator, had a "use by date" of January 18, 2015. This was brought to the attention of the RCC and subsequently discarded.

Inspector #544 identified January 22, 2015; that the medication refrigerator temperatures were not accurate. When Inspector #544 opened the medication refrigerator, the temperature read 1 degree celcius. When Inspector #544 closed the medication refrigerator door, the temperature read minus 44 degrees celcius then a few seconds later, minus 34 degrees celcius and then shortly after the reading changed to 2 degrees celcius.

The RCC and staff member #106 confirmed this. They both advised that a maintenance staff member had fixed the thermometer that morning, before the inspector's arrival, as it had not been working well for some time. The refrigerator thermometer still did not appear to be working as it should.

The documentation and recording of the medication refrigerator temperatures for the month of January 2015, ranged from minus 1 degree celcius to 6 degrees celcius on one Wing of the home. The refrigerator temperature was taken once daily.

The documentation and recording of the medication refrigerator temperatures for the month of January 2015, ranged from minus 1 degree celcius to 10 degress celcius on the other Wing. The refrigerator temperature was taken once daily.

There were a number of medications in the medication refridgerator and this was brought immediately to the RCC and staff member #106's attention.

Inspector #544 reviewed the home's policy; Drug Storage refrigeration- Effective date May 2014 and it is documented; "The internal temperature of the refrigerator must be between 2-8 degrees celcius. Temperatures outside of this range must be reported to the Director of Care immediately for immediate action as to replacement."

The licensee failed to ensure that drugs stored in an area comply with manufacturer's instructions for the storage of drugs such as expiry dates and refrigeration temperatures. [s. 129. (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 ensuring that the home has a process in place to ensure that the refrigeration system used to store medications is maintained at a temperature recommended by the manufacturer and as per the homes policy. A process should also be implemented ensuring that no medications are used past the use by date as determined by the manufacturer., 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. Observations by inspector #593 found that Resident #018 had bilateral side rails in the up position. However, a review of Resident #018's current plan of care found no documentation related to bed rail use.

During an interview with Inspector #593 January 27, 2015; staff member #110 confirmed that bilateral bed rails are in place for Resident #018 and that they are used for mobility and safety in bed. Staff member #110 advised that bed rails have been used for this resident for several years.

During an interview with Inspector #593 January 26, 2015; the homes DOC confirmed that Resident #018 does use bed rails for mobility and safety and that this should be included in the residents plan of care.

As such the licensee has failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. Inspector # 544 toured the home on January 19, 2014 at 10:00 and identified that the baseboards in the hallways in the South section of the home were very dusty and the dust was sitting on top of the baseboards.

Inspector #544 interviewed staff member #108 who confirmed that the cleaning of the wooden baseboards, along the South side of the home's hallways, were not on any cleaning schedule for the housekeeping staff to clean. During a walk through the South side of the home, they also confirmed that the baseboards were very dusty and will ensure that they are cleaned immediately.

Staff members #100 and #101 both confirmed that this cleaning duty was not on any cleaning list assignment and therefore is missed.

As part of the organized program of housekeeping, the licensee failed to ensure that procedures are developed and implemented for, (a) cleaning of the home's common areas including floors, carpets, furnishings, contact surfaces and wall surfaces. [s. 87. (2) (a) (ii)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. Inspector #544 observed a medication pass by staff member #106 and identified that staff member #106 did not wash or santitize their hands on a regular basis between residents receiving medications and other care and service tasks.

Staff member #106 picked up garbage from the floor and proceeded to Resident #017's room to administer medication without sanitizing or washing their hands after picking up the garbage. After staff member #106 administered the medication to Resident #017, staff member #106 did not wash or sanitize their hands once again and placed the medication container in the medication drawer. Staff member #106 then signed their initials on the medication administration record with their pen, as the medication was administered, and proceeded to the next resident without washing or sanitizing their hands.

Staff member #106 also laid out eight disposable cups for the administration of a Two Cal nutritional supplement, on the top of the medication cart. As they were placing the disposable cups on the medication cart, they placed their fingers in the empty disposable cups and carried four cups at a time with one finger in each cup.

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

Issued on this 12th day of February, 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

Licensee Copy/Copie du titulaire de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN CHAMBERLIN (593), FRANCA MCMILLAN (544), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2015_380593_0002
Log No. / Registre no:	S-000664-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 6, 2015
Licensee / Titulaire de permis :	ESPANOLA GENERAL HOSPITAL 825 MCKINNON DRIVE, ESPANOLA, ON, P5E-1R4
LTC Home / Foyer de SLD :	ESPANOLA GENERAL HOSPITAL (2932) 825 MCKINNON DRIVE, ESPANOLA, ON, P5E-1R4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	RAY HUNT

To ESPANOLA GENERAL HOSPITAL, 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 ensure that each and every resident in the home is assessed and their bed system evaluated in accordance with evidence-based practices and that the recommendations from the assessments and evaluations are complied with.

Grounds / Motifs :

1. During an interview with Inspector #593 January 22, 2015; the home's Director Of Care (DOC) advised that there has been no bed system evaluation undertaken internally or externally within the home. Furthermore, they advised that the home does not have a process in place to ensure that all residents with bed rails are assessed or their bed system evaluated. To their knowledge, this has not been undertaken in the home in the past six years.

As such the licensee has failed to ensure 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 the risk to the resident. (593)

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

Order # / Ordre no : 002

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 each and every resident in the home is assessed and their bed system evaluated in accordance with evidence-based practices and that the recommendations from the assessments and evaluations are complied with. Furthermore, steps must be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment including but not limited to new bed systems or components of a bed system.

Grounds / Motifs :

1. During stage 1 of the Resident Quality Inspection, Inspector's #593 and #544 identified numerous bed systems with spaces in Zone 7 with potential for head entrapment at both the headboard and footboard.

According to the Health Canada Guidance Document- Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and other Hazards dated March 17, 2008; Zone 7 is defined as "the space between the inside surface of the headboard or footboard and the end of the mattress". Furthermore, according to this document, this space may present a risk of head entrapment when taking into account the mattress compressibility, any shift of the mattress, and degree of play from a loosened headboard or footboard. Health Canada recognizes this area as a potential for entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in

intermediate positions.

The three key body parts at risk for life-threatening entrapment in the seven zones of a hospital bed system discussed in the guidance are the head, neck and chest. International anthropometric data references have been used to determine the relative sizes of these body parts for the population at greatest risk for entrapment and to provide a guide for the dimensional limits that would reduce their risk of entrapment. To reduce the risk of head entrapment, openings in the bed system should not allow the widest part of a small head to be trapped. Health Canada is therefore using a head breadth dimension of 120mm as the basis for its dimensional limit recommendations. The population at greatest risk is defined as "patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement or who get out of bed and walk unsafely without assistance. These patients most often have been frail, elderly or confused".

The Health Canada Guidance Document was sent to all licensees of Ontario August 21, 2012; by the Acting Director of the Ministry of Health and Long-Term Care. It was highlighted that "institutions should verify that replacement mattresses are the correct size for the bed frame" and that "the risk of entrapment of residents in hospital-type beds is of such a critical nature; please ensure that your organization follows the Health Canada recommendations and complies with the regulatory requirements to ensure the safety of residents in your LTC home".

Measurements were undertaken during the course of the inspections of all the bed systems within the home that a potential entrapment concern was observed in Zone 7. The following measurements listed had bed systems where the Zone 7 measurement exceeded the 120mm Health Canada recommendation for preventing head entrapment. It should be noted that all of the mentioned room numbers and corresponding bed systems except for room's #545A and #311B had bed rails in use at the time of the inspection.

The following measurements were taken, taking into account shifting of the mattress from one end of the bed to the other as per the Health Canada bed entrapment guidance document. Therefore the maximum space allowed by shifting of the mattress was measured. It should be mentioned however that the compressibility of the mattress was not measured therefore the following measurements have the potential to be greater if measured taking into account

the compressibility of the mattress and the weight of a human head.

• Room #514A- Zone 7 headboard = 140mm
• Room #540A- Zone 7 headboard =178mm
• Room #545A- Zone 7 footboard =170mm
• Room #523- Zone 7 headboard =127mm
• Room #522- Zone 7 headboard = 203mm
• Room #520- Zone 7 footboard = 155mm
• Room #317A- Zone 7 headboard = 145mm
• Room #315B- Zone 7 footboard =155mm
• Room #313A- Zone 7 headboard = 163mm
• Room #313B- Zone 7 footboard: =206mm
• Room #311B- Zone 7 headboard = 180mm
• Room #303A- Zone 7 headboard = 140mm
• Room #305B- Zone 7 headboard = 157mm
• Room #307B- Zone 7 headboard = 155mm
• Room #306A- Zone 7 headboard = 127mm
• Room #306C- Zone 7 headboard = 127mm
• Room #304B- Zone 7 headboard = 132mm
• Room #308A- Zone 7 headboard = 130mm
• Room #310A- Zone 7 headboard

= 145mm
• Room #305A- Zone 7 headboard
= 130mm
• Room #306B- Zone 7 headboard
= 127mm

The following bed systems had two mattresses in place therefore the measurement was taken from the shorter mattress which was the top mattress in all three bed systems. The shifting of the top mattress over the base mattress was also taken into account when the measurements were undertaken.

• Room #317B- Zone 7 headboard
= 259mm
• Room #304C- Zone 7 headboard
= 282mm
• Room #302- Zone 7 headboard
= 157mm

During an interview with Inspector #593 January 22, 2015; the home's DOC advised that there has been no bed system evaluation undertaken internally or externally within the home. Furthermore, they advised that the home does not have a process in place to ensure that all residents with bed rails are assessed or their bed system evaluated. To their knowledge, this has not been undertaken in the home in the past six years.

According to the Health Canada Guidance Document Zone 7 may present a risk of head entrapment therefore the bed systems mentioned present potential risk to residents within the home for entrapment in this zone, as frail, elderly and confused residents are at the greatest risk for bed entrapment. Furthermore as no bed system evaluation has been undertaken, further risk may be present which can only be identified when a bed system evaluation is undertaken by a trained provider using the appropriate measuring tools.

As such, the licensee has failed to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 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 6th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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