



**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**

London Service Area Office  
130 Dufferin Avenue 4th floor  
LONDON ON N6A 5R2  
Telephone: (519) 873-1200  
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130 avenue Dufferin 4ème étage  
LONDON ON N6A 5R2  
Téléphone: (519) 873-1200  
Télécopieur: (519) 873-1300

## Public Copy/Copie du public

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Oct 6, 2015	2015_303563_0032	008599-15, 008334-15, 008984-15	Critical Incident System

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### Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.  
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE PORT STANLEY  
4551 EAST ROAD PORT STANLEY ON N5L 1J6

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

MELANIE NORTHEY (563)

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## Inspection Summary/Résumé de l'inspection

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 8, 2015**

**The following inspections were conducted concurrently during this RQI inspection:**

**Log # 008334-15: Follow-up Inspection to L-002092-15**

**Log # 008984-15: Complaint related to housekeeping concerns**

**Log # 008599-15/CI 2669-000009-15: bed rail entrapment**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Assessment Instrument Coordinator, the Director of Care, the Dietary Manager, one housekeeper and one Resident.**

**The inspector also reviewed relevant policies, procedures and education records, as well as the clinical record for the identified resident. Observations of housekeeping practices and cleanliness of the home in common areas and in the dining room were also conducted.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**

**Safe and Secure Home**

**Training and Orientation**

**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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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**



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**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 had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Record review of the clinical record for Resident # 001 revealed the absence of a documented bed assessment for the use of bed rails.

During the Resident Quality Inspection (RQI) in April 2015, a record review of the "Bed Entrapment Worksheet" revealed it was completed December 4, 2014 by the Maintenance Supervisor and the RAI Coordinator. At that time all bed systems were evaluated, however the home did not complete a bed assessment for any resident using bed rails and confirmed there was no formal assessment in PointClickCare to assess a resident where bed rails were used. This area of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) on July 7, 2014 and April 10, 2015.

Record review of the "Long Term Care Home Plan of Corrective Action for Inspection Number 2015\_303563\_0014" revealed:

- Short Term Action: "Assess all residents for the use of bed rails and documentation to support."

- Long Term Action: "Develop bed assessment tool and review quarterly with each resident and/or when there is a significant change."

The plan of correction did not have time lines for completion and the Director of Care (DOC) confirmed a tool has not been developed or implemented for any resident using bed rails. The DOC also confirmed any resident who used side rails has not been assessed for risk of entrapment.

Staff interview with the DOC and the RAI-C confirmed greater than 90% of residents in the home used one or more side rails and confirmed that the residents had not been assessed for risk of entrapment where bed rails were used. [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 6th day of October, 2015**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**



**Ministry of Health and  
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des Soins de longue durée**

**Order(s) of the Inspector**

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

**Ordre(s) de l'inspecteur**

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

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

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

**Public Copy/Copie du public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** MELANIE NORTHEY (563)

**Inspection No. /**

**No de l'inspection :** 2015\_303563\_0032

**Log No. /**

**Registre no:** 008599-15, 008334-15, 008984-15

**Type of Inspection /**

**Genre**

**d'inspection:**

Critical Incident System

**Report Date(s) /**

**Date(s) du Rapport :** Oct 6, 2015

**Licensee /**

**Titulaire de permis :** EXTENDICARE (CANADA) INC.  
3000 STEELES AVENUE EAST, SUITE 700,  
MARKHAM, ON, L3R-9W2

**LTC Home /**

**Foyer de SLD :** EXTENDICARE PORT STANLEY  
4551 EAST ROAD, PORT STANLEY, ON, N5L-1J6

**Name of Administrator /**

**Nom de l'administratrice**

**ou de l'administrateur :** Anne Wouters

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To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order(s) of the Inspector**

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

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
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**Order # /**

Ordre no : 001

**Order Type /**

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

**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 must achieve compliance to ensure when bed rails are used,  
(a) the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. O.Reg. 79/10, s. 15 (1)  
(a).

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s. 15 (1) (a).

Please submit the plan, in writing, to Melanie Northey, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, by email to [melanie.northey@ontario.ca](mailto:melanie.northey@ontario.ca) by October 14, 2015.

Date to be complied: November 6, 2015.

**Grounds / Motifs :**





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

Record review of the clinical record for Resident # 001 revealed the absence of a documented bed assessment for the use of bed rails.

During the Resident Quality Inspection (RQI) in April 2015, a record review of the "Bed Entrapment Worksheet" revealed it was completed December 4, 2014 by the Maintenance Supervisor and the RAI Coordinator. At that time all bed systems were evaluated, however the home did not complete a bed assessment for any resident using bed rails and confirmed there was no formal assessment in PointClickCare to assess a resident where bed rails were used. This area of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) on July 7, 2014 and April 10, 2015.

Record review of the "Long Term Care Home Plan of Corrective Action for Inspection Number 2015\_303563\_0014" revealed:

- Short Term Action: "Assess all residents for the use of bed rails and documentation to support."
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The plan of correction did not have time lines for completion and the Director of Care (DOC) confirmed a tool has not been developed or implemented for any resident using bed rails. The DOC also confirmed any resident who used side rails has not been assessed for risk of entrapment.

Staff interview with the DOC and the RAI-C confirmed greater than 90% of residents in the home used one or more side rails and confirmed that the residents had not been assessed for risk of entrapment where bed rails were used. (563)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2015**



**Ministry of Health and  
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**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
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**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



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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](http://www.hsarb.on.ca).



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## **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, 11<sup>e</sup> 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.



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de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée, L.O. 2007, chap. 8*

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

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

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

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

**Issued on this 6th day of October, 2015**

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

**Name of Inspector /  
Nom de l'inspecteur :** Melanie Northey

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