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) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2013_204133_0026
Log No. / Registre no:	S-000965-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 4, 2013
Licensee / Titulaire de permis :	F. J. DAVEY HOME 733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1
LTC Home / Foyer de SLD :	F. J. DAVEY HOME 733 Third Line East, Sault Ste Marie, ON, P6A-7C1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER J. MACLEAN

To F. J. DAVEY HOME, 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2012_099188_0027, CO #005;

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 prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10. s. 15. (1)(b), which outlines the requirement that the licensee must ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. The plan must address the April 2013 bed system evaluation, and clearly identify how all bed rails that failed the entrapment Zone testing have been dealt with so they are no longer a safety risk to any resident. The plan must specifically outline what immediate steps the licensee has taken to ensure the safety of all residents who have unsecured 3/4 bed rails on "MC Healthcare" beds. The plan must be fully implemented by October 31, 2013.

The plan is to be submitted in writing by October 11th 2013 to LTC Homes Inspector Jessica Lapensee at 347 Preston Street, Ottawa, Ontario, K1S-3J4. The plan may be faxed to the inspector's attention at (613) 569-9670.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s.15 (1)(b) in that, where bed rails are used, the licensee has failed to take steps to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During the inspection, bed rails that present a risk of entrapment were found on forty seven resident beds, which presents a widespread risk for the residents of the home.

2. In April 2013, a full home evaluation of every resident bed with bed rails was conducted by a representative of the company "Motion Specialty" and one of the home's maintenance workers. This evaluation was done in accordance with the Health Canada guidance document, titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (the HC document), with an effective date of 2008/03/17. This document describes seven zones where there is a potential for resident entrapment, and sets out dimensional limits for Zones 1-4. The HC document describes Zone 1 as "within the rail" and the test assesses the potential for head entrapment within the perimeter of the bed rail. The HC document describes Zone 4 as "under the rail at the end of the rail", and the test assesses the potential for neck entrapment between the top of the mattress and the lower-most portion of the bed rail, at the end of the bed rail. The inspector reviewed the April 2013 documented evaluation of resident beds with bed rails, on September 26th 2013, during the inspection. The evaluation identified that bed rails on 169 resident beds failed in either Zone 1 (4 beds) or Zone 4 (165 beds). The vast majority of the bed rails that failed were ¾ bed rails, on "MC Healthcare" resident beds. These ¾ rails all failed in Zone 4 regardless of mattress type in use, due to the nature of their design.

3. On September 26th 2013, during the inspection, the inspector reviewed an audit done by nursing staff, covering 9 of the 12 resident care units. This audit noted, in part, if there were bed rails on a resident's bed which could be positioned up or down (i.e not tied down), the type of rails (3/4 vs. 1/2), and if the rails were in use. This document was provided to the inspector on September 25th 2013, by the Director of Environmental Services (the DES), who indicated that she had received it within the last few days. The document is not dated, but each sheet does have a "printed on" date of 29/08/2013. Guided by the information in this audit, on September 26th 2013, the inspector visually confirmed that on 47 "MC Healthcare" resident beds in the home, there was a ¾ rail which could be positioned up or down, on one or both sides of the bed. These 3/4 bed rails were therefore readily usable, and all of them present a risk for resident entrapment in Zone 4 if they were to be used. Based on the information in the nursing audit, and the inspector's observations, the majority of

the 3/4 bed rails, on at least one side of the bed, were in use at the time of the inspection.

4. The DES explained to the inspector that following the April 2013 bed rail evaluation, based on direction from the nursing department, some of the bed rails were removed, some were rendered unusable (i.e. tied down, on one or both sides of the bed), and others were left as is. The DES further explained that in July 2013, bed rails which initially failed, on "Carroll Echo" resident beds (14 beds) were retro fitted, and this rendered them safe for use. The DES indicated that the ¾ bed rails for the "MC Healthcare" resident beds cannot be retro fitted.

5. It is noted that the licensee has a history of non-compliance with O. Reg 79/10, s.15. (1). Compliance Order (CO) #005 was issued to the home in July 2012, as a result of Follow-Up inspection # 2012_099188_0027. The grounds that supported the CO were specific to O. Reg. 79/10, s.15.(1)(a), requiring the licensee to submit a plan for achieving compliance with the requirement to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices. While all bed systems were evaluated in accordance with evidence-based practices, in April 2013, the licensee has now failed to comply specifically with O. Reg 79/10, s.15.(1)(b), as steps have not been taken to prevent resident entrapment, in Zone 4, as was identified by the evaluation. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2013

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2012_099188_0027, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Order / Ordre :

The licensee will ensure compliance with O. Reg. 79/10, s.101 (2) by ensuring that an accurate documented record of complaints, which includes all requirements identified in the regulations, is maintained.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s.101 (2) in that the licensee has failed to ensure that a documented record is maintained, related to complaints, as prescribed by the regulation.

2. The inspector reviewed the home's documented complaint record on September 26th 2013, in collaboration with the Director of Resident and Staff Services. The record is comprised of a spreadsheet which summarizes details of each complaint, and an associated file for each logged complaint, which contains more in-depth information. The Director of Resident and Staff Services explained to the inspector that this record does not include verbal complaints that are resolved within 24 hours of the complaint being received, as this is not a requirement of the legislation. Prior to the inspection, the inspector had been made aware of a complaint, concerning the care of resident #001 and the

operation of the home. The complaint was made by a member of the resident's family, on June 13, 2013, via email, to the Administrator. The inspector found that the complaint was not included in the home's documented complaint record.

3. The inspector also reviewed a selection of complaints that were included in the home's documented complaint record. The inspector noted the following:

a) The record, related to complaint #2013_1122, regarding a lack of care supplies, did not include a date on which a response was provided to the complainant.

b) The record, relating to complaint #2013_1110, regarding a resident's clothing, did not indicate if a response was made to the complainant.

c) The record, relating to complaint #2013_1030, regarding a resident privacy issue, did not indicate if a response was made to the complainant.

d) The record, relating to complaint #2013_1115, regarding a resident's food allergy, did not indicate if a response was made to the complainant.

e) The record, relating to complaint #2013_1126, regarding a resident's bed linens, did not indicate if a response was made to the complainant.

f) The record, relating to complaint #2013_1124, regarding a resident's care, did not indicate if a response was made to the complainant.

4. It is noted that the licensee has a history of non-compliance with O. Reg. 79/10, s. 101. In October 2013, a Written Notification and Voluntary Plan of Correction was issued to the home, as a result of Complaint Inspection #2013_246196_0004. The findings of this non compliance were specifically related to O. Reg. 79/10, s. 101.(1)(3). In July 2012, Compliance Order (CO) #003 was issued to the home, as a result of Follow Up inspection # 2012_099188_0027. The grounds that supported this CO were specific to O. Reg. 79/10, s.101.(1) and (2). Previous to this, CO # 001 was issued to the home in March 2012, as a result of Complaint inspection # 2012_099188_0006. The grounds that supported this CO were specific to O. Reg. 79/10, s. 101.(1) (1), s. 101.(1)(3), s. 101.(2) and s. 101.(3). (133)

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 : Oct 18, 2013

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2012_099188_0027, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s.17.(1) (b) and (c), which outlines the requirement that the licensee shall ensure that the home is equipped with a resident-staff communication and response system that is on at all times, and which allows calls to be cancelled only at the point of activation. The plan must be fully implemented by November 29th, 2013.

The plan is to be submitted in writing by October 11th, 2013, to LTC Homes Inspector Jessica Lapensee at 347 Preston Street, Ottawa, Ontario, K1S-3J4. The plan may be faxed to the inspector's attention at (613) 569-9670.

Grounds / Motifs :

1. The home is equipped with a wireless resident-staff communication and response system (the system). Some residents and all nursing staff are provided with a Personal Alert Badge (PAB) which allows the user to call for assistance from anywhere within the home. The system sensors throughout the home

interface with these PABs, reflecting the location of the person wearing the PAB when the system last sensed them. Every nursing staff member is required to wear their PAB at all times while on shift. Some residents wear their PABs at all times as their primary method to call for assistance. As well, in every common area, in all resident washrooms, and at all resident's bedside, there is a remote pull station on the wall which allows anyone who is not wearing a PAB to call for assistance. On the care units, Personal Support Workers (PSWs) are required to carry a pager which interfaces with the wireless system and alerts them to incoming calls for assistance. Above all resident bedroom and common area doorways, there are dome lights. A white light illuminates when a call is made with a PAB or from a remote station. The PABs worn by nursing staff will cause this white light to turn off and a green light to turn on, which cancels the call for assistance and signals that a staff person is present and responding to the call.

The licensee has failed to comply with O. Reg. 79/10, s.17 (1)b. in that the licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times.

On September 25th 2013, during the inspection, the inspector found that resident #002, #003, #004,#005's PABs were not able to produce a call for assistance. When tested, white dome lights did not illuminate above the door and nursing staff in the area confirmed they had not received a call for assistance on their pagers. Resident #006's PAB only worked intermittently when tested. With the exception of resident #004, each of these residents was wearing their PAB when it was tested, with the expectation that it was functional and could produce a call for assistance. Resident #004 was in their bed and their PAB was clipped to their shirt, which they had placed next to them in their bed, for ready access. At each care unit nurse station, there is a dedicated system computer console which notes the last time, and location, that the system detected the PABs. At 7:04 pm on September 25th 2013, the inspector noted that the last time resident #005's PAB had been detected by the system was at 7:36am on September 24th 2013. When the PAB batteries need to be changed, a lightning bolt symbol appears next to the residents name on the dedicated system computer console at the care unit nurse station. The inspector was triggered to check resident #003, #004, #005 and #006 PABs as there was a lightning bolt next to their names. The inspector tested residents #006's PAB at 7:25pm on September 25th 2013, and it is noted that there had been a lightning bolt next to this resident's name since at least 10am on that day. (133)

2. The licensee has failed to comply with O. Reg. 79/10, s.17 (c) in that the licensee has failed to ensure the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation.

On September 25th 2013, during the inspection, the inspector noted that calls made from the bathroom in five private resident rooms (D114, D112, D125, C225, C227) could be turned off from the hallway, close to the entrance of the bedroom. The inspector verified this by making a call from the bathroom remote pull station, while not in possession of the tester PAB, then going back to the hallway, holding the tester PAB, and walking slowly towards the bedroom until the green dome light came on. The green light turns off the white dome light and cancels the call for assistance. The home's IT support person accompanied the inspector to verify this in three of the identified rooms, and given the configuration of the system sensors in these private rooms, he assumed that this would be the case in all of the private rooms in the home. Similarly, the inspector noted that calls made from within some resident bedrooms could be turned off from the hallway, close to the entrance of the room. This was noted in the following bedrooms: D108, D107, D109, D110, D112, D114, C225, C227, C220, C207 and C214. The inspector found that the distance from which calls from the bathroom or bedroom could be turned off varied from approximately 45 centimeters to just outside of the entrance to the bedroom. The distance appeared to be primarily affected by the position of the bedroom door, if it was fully open then the distance was greater as the sensor within the bedroom ceiling was not hindered and could detect the signal from the tester PAB more readily.

On September 24th 2013, during the inspection, the home's IT support person informed the inspector that calls from the resident-staff communication and response system can be cancelled remotely, from the main computer console in his office and from the system computer consoles at the nurse station in each care unit. The IT support person explained that he and the charge nurses had the password that could be used to cancel a call from a system computer console.

It is noted that the licensee has a history of non-compliance with O. Reg. 79/10, s.17 (1). This history most recently includes Compliance Order #001, issued to

the home in July 2012, as a result of follow up inspection # 2012_099188_0027. Previous to this, Compliance Orders #901 and #902 were issued to the home in February 2012, as a result of Resident Quality Inspection #2012_099188_0005. (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2013

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.

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

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 4th day of October, 2013

Signature of Inspector / Signature de l'inspecteur : Jessica Lapensée

Name of Inspector / Nom de l'inspecteur : JESSICA LAPENSEE

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 4, 2013	2013_204133_0026	S-000965-12	Follow up

Licensee/Titulaire de permis

F. J. DAVEY HOME
733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1

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

F. J. DAVEY HOME
733 Third Line East, Sault Ste Marie, ON, P6A-7C1

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 24 - 27, 2013

During the course of the inspection, the inspector(s) spoke with the Senior Administrator, the acting Executive Director of Resident Nursing Services, the Director of Resident and Staff Services, the Director of Environmental Services, the Assistant Director of Environmental Services, the IT support person, maintenance workers, registered and non registered nursing staff, residents and a resident's visiting family member.

During the course of the inspection, the inspector(s) tested the operation of the resident-staff communication and response system, reviewed documentation related to the home's April 2013 bed system evaluation and subsequent actions taken, reviewed a recent nursing department audit of bed rails in use in 9 of 12 care units, observed bed rails on resident's beds, reviewed a selection of the nursing department's equipment requisition forms related to bed rails and reviewed the home's documented record related to complaints including a selection of complaint files

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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
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 comply with O. Reg. 79/10, s.15 (1)(b) in that, where bed rails are used, the licensee has failed to take steps to prevent resident entrapment, taking into consideration all potential zones of entrapment. During the inspection, bed rails that present a risk of entrapment were found on forty seven resident beds, which presents a widespread risk for the residents of the home.

2. In April 2013, a full home evaluation of every resident bed with bed rails was conducted by a representative of the company "Motion Specialty" and one of the home's maintenance workers. This evaluation was done in accordance with the Health Canada guidance document, titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (the HC document), with an effective date of 2008/03/17. This document describes seven zones where there is a potential for resident entrapment, and sets out dimensional limits for Zones 1-4. The HC document describes Zone 1 as "within the rail" and the test assesses the potential for head entrapment within the perimeter of the bed rail. The HC document describes Zone 4 as "under the rail at the end of the rail", and the test assesses the potential for neck entrapment between the top of the mattress and the lower-most portion of the bed rail, at the end of the bed rail. The inspector reviewed the April 2013 documented evaluation of resident beds with bed rails, on September 26th 2013, during the inspection. The evaluation identified that bed rails on 169 resident beds failed in either Zone 1 (4 beds) or Zone 4 (165 beds). The vast majority of the bed rails that failed were ¾ bed rails, on "MC Healthcare" resident beds. These ¾ rails all failed in Zone 4 regardless of mattress type in use, due to the nature of their design.

3. On September 26th 2013, during the inspection, the inspector reviewed an audit done by nursing staff, covering 9 of the 12 resident care units. This audit noted, in part, if there were bed rails on a resident's bed which could be positioned in the up or down position (i.e not tied down), the type of rails (3/4 vs. 1/2), and if the rails were in use. This document was provided to the inspector on September 25th 2013, by the Director of Environmental Services (the DES), who indicated that she had received it within the last few days. The document is not dated, but each sheet does have a "printed on" date of 29/08/2013. Guided by the information in this audit, on September 26th 2013, the inspector visually confirmed that on 47 "MC Healthcare" resident beds in the home, there was a ¾ rail which could be positioned up or down, on one or both sides of the bed. These 3/4 bed rails were therefore readily usable, and all of them present a risk for resident entrapment in Zone 4 if they were to be used. Based on the

information in the nursing audit, and the inspector's observations, the majority of the 3/4 bed rails, on at least one side of the bed, were in use at the time of the inspection.

4. The DES explained to the inspector that following the April 2013 bed rail evaluation, based on direction from the nursing department, some of the bed rails were removed, some were rendered unusable (i.e tied down, on one or both sides of the bed), and others were left as is. The DES further explained that in July 2013, bed rails which initially failed, on "Carroll Echo" resident beds (14 beds) were retro fitted, and this rendered them safe for use. The DES indicated that the ¾ bed rails for the "MC Healthcare" resident beds cannot be retro fitted.

5. It is noted that the licensee has a history of non-compliance with O. Reg 79/10, s.15. (1). Compliance Order (CO) #005 was issued to the home in July 2012, as a result of Follow-Up inspection # 2012_099188_0027. The grounds that supported the CO were specific to O. Reg. 79/10, s.15.(1)(a), requiring the licensee to submit a plan for achieving compliance with the requirement to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices. While all bed systems were evaluated in accordance with evidence-based practices, in April 2013, the licensee has now failed to comply specifically with O. Reg 79/10, s.15.(1)(b), as steps have not been taken to prevent resident entrapment, in Zone 4, as was identified by the evaluation. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s.101 (2) in that the licensee has failed to ensure that a documented record is maintained, related to complaints, as prescribed by the regulation.

2. The inspector reviewed the home's documented complaint record on September 26th 2013, in collaboration with the Director of Resident and Staff Services. The record is comprised of a spreadsheet which summarizes details of each complaint, and an associated file for each logged complaint, which contains more in-depth information. The Director of Resident and Staff Services explained to the inspector that this record does not include verbal complaints that are resolved within 24 hours of the complaint being received, as this is not a requirement of the legislation. Prior to the inspection, the inspector had been made aware of a complaint, concerning the care of resident #001 and the operation of the home. The complaint was made by a member of the resident's family, on June 13, 2013, via email, to the Administrator. The inspector found that the complaint was not included in the home's documented complaint record.

3. The inspector also reviewed a selection of complaints that were included in the home's documented complaint record. The inspector noted the following:

a) The record, related to complaint #2013_1122, regarding a lack of care supplies, did not include a date on which a response was provided to the complainant.

b) The record, relating to complaint #2013_1110, regarding a resident's clothing, did not indicate if a response was made to the complainant.

c) The record, relating to complaint #2013_1030, regarding a resident privacy issue, did not indicate if a response was made to the complainant.

d) The record, relating to complaint #2013_1115, regarding a resident's food allergy, did not indicate if a response was made to the complainant.

e) The record, relating to complaint #2013_1126, regarding a resident's bed linens, did not indicate if a response was made to the complainant.

f) The record, relating to complaint #2013_1124, regarding a resident's care, did not indicate if a response was made to the complainant.

4. It is noted that the licensee has a history of non-compliance with O. Reg. 79/10, s. 101. In October 2013, a Written Notification and Voluntary Plan of Correction was issued to the home, as a result of Complaint Inspection #2013_246196_0004. The findings of this non compliance were specifically related to O. Reg. 79/10, s. 101.(1) (3). In July 2012, Compliance Order (CO) #003 was issued to the home, as a result of Follow Up inspection # 2012_099188_0027. The grounds that supported this CO were specific to O. Reg. 79/10, s.101.(1) and (2). Previous to this, CO # 001 was issued to the home in March 2012, as a result of Complaint inspection # 2012_099188_0006. The grounds that supported this CO were specific to O. Reg. 79/10, s. 101.(1)(1), s. 101.(1)(3), s. 101.(2) and s. 101.(3). [s. 101. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The home is equipped with a wireless resident-staff communication and response system (the system). Some residents and all nursing staff are provided with a Personal Alert Badge (PAB) which allows the user to call for assistance from anywhere within the home. The system sensors throughout the home interface with these PABs, reflecting the location of the person wearing the PAB when the system last sensed them. Every nursing staff member is required to wear their PAB at all times while on shift. Some residents wear their PABs at all times as their primary method to call for assistance. As well, in every common area, in all resident washrooms, and at all resident's bedside, there is a remote pull station on the wall which allows anyone who is not wearing a PAB to call for assistance. On the care units, Personal Support Workers (PSWs) are required to carry a pager which interfaces with the wireless system and alerts them to incoming calls for assistance. Above all resident bedroom and common area doorways, there are dome lights. A white light illuminates when a call is made with a PAB or from a remote station. The PABs worn by nursing staff will cause this white light to turn off and a green light to turn on, which cancels the call for assistance and signals that a staff person is present and responding to the call.

The licensee has failed to comply with O. Reg. 79/10, s.17 (1)b. in that the licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times.

On September 25th 2013, during the inspection, the inspector found that resident #002, #003, #004,#005's PABs were not able to produce a call for assistance. When tested, white dome lights did not illuminate above the door and nursing staff in the area confirmed they had not received a call for assistance on their pagers. Resident #006's PAB only worked intermittently when tested. With the exception of resident #004, each of these residents was wearing their PAB when it was tested, with the expectation that it was functional and could produce a call for assistance. Resident #004 was in their bed and their PAB was clipped to their shirt, which they had placed next to them in their bed, for ready access. At each care unit nurse station, there is a dedicated system computer console which notes the last time, and location, that the system detected the PABs. At 7:04 pm on September 25th 2013, the inspector noted that the last time resident #005's PAB had been detected by the system was at 7:36am on September 24th 2013. When the PAB batteries need to be changed, a lightning bolt symbol appears next to the residents name on the dedicated system computer console at the care unit nurse station. The inspector was triggered to check

resident #003, #004, #005 and #006 PABs as there was a lightning bolt next to their names. The inspector tested residents #006's PAB at 7:25pm on September 25th 2013, and it is noted that there had been a lightning bolt next to this resident's name since at least 10am on that day. [s. 17. (1) (b)]

2. The licensee has failed to comply with O. Reg. 79/10, s.17 (c) in that the licensee has failed to ensure the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation.

On September 25th 2013, during the inspection, the inspector noted that calls made from the bathroom in five private resident rooms (D114, D112, D125, C225, C227) could be turned off from the hallway, close to the entrance of the bedroom. The inspector verified this by making a call from the bathroom remote pull station, while not in possession of the tester PAB, then going back to the hallway, holding the tester PAB, and walking slowly towards the bedroom until the green dome light came on. The green light turns off the white dome light and cancels the call for assistance. The home's IT support person accompanied the inspector to verify this in three of the identified rooms, and given the configuration of the system sensors in these private rooms, he assumed that this would be the case in all of the private rooms in the home. Similarly, the inspector noted that calls made from within some resident bedrooms could be turned off from the hallway, close to the entrance of the room. This was noted in the following bedrooms: D108, D107, D109, D110, D112, D114, C225, C227, C220, C207 and C214. The inspector found that the distance from which calls from the bathroom or bedroom could be turned off varied from approximately 45 centimeters to just outside of the entrance to the bedroom. The distance appeared to be primarily affected by the position of the bedroom door, if it was fully open then the distance was greater as the sensor within the bedroom ceiling was not hindered and could detect the signal from the tester PAB more readily.

On September 24th 2013, during the inspection, the home's IT support person informed the inspector that calls from the resident-staff communication and response system can be cancelled remotely, from the main computer console in his office and from the system computer consoles at the nurse station in each care unit. The IT support person explained that he and the charge nurses had the password that could be used to cancel a call from a system computer console.

It is noted that the licensee has a history of non-compliance with O. Reg. 79/10, s.17

(1). This history most recently includes Compliance Order #001, issued to the home in July 2012, as a result of follow up inspection # 2012_099188_0027. Previous to this, Compliance Orders #901 and #902 were issued to the home in February 2012, as a result of Resident Quality Inspection #2012_099188_0005. [s. 17. (1) (c)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 4th day of October, 2013

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

Jessica Lapensée