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
Jan 11, 2016 Amended: April 5, 2016	**2016_284545_0002**	**036487-15**	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF CORNWALL
1900 Montreal Rd. CORNWALL ON K6H 7L1

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

GLEN-STOR-DUN LODGE
1900 MONTREAL ROAD CORNWALL ON K6H 7L1

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

ANGELE ALBERT-RITCHIE (545)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 5 and 6, 2016

The report was amended to reflect some wording changes as per discussions with the Home on March 9, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Environmental Services Supervisor (ESS), Consultant Pharmacist from Classic Care Pharmacy, Kinesiologist, one Registered Nurse, two Registered Practical Nurses (RPN), several Personal Care Workers (PSW), one Environmental Services Staff.

The inspector also conducted a tour of a Resident care area, observed Resident #001's bedroom and bed system, reviewed Resident #001's health care records, including plan of care, medication administration record, home policies and procedures, staff work routines and schedules, bed system assessment record and observed delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Personal Support Services

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented to ensure that, electrical and non-electrical equipment, such as resident's bed systems are kept in good repair, and maintained at a level that meets manufacturer specifications, at a minimum.

Upon review of a Critical Incident Report (CIR) submitted by the home on a specific date in December 2015, it was documented that Resident #001 was found lying in a pool of blood that same morning with no vital signs. A note in the CIR indicated that upon the coroner's assessment, it was determined that the cause of death was due to a large blood loss from an accidental vascular laceration to a specific limb in the setting of anticoagulant therapy.

In a review of the death certificate with a specific date in December 2015, signed by the coroner, it was documented that the resident's death was caused by an accidental cut injury to a specific limb at site of a vascular disease to edge of bed.

During an observation of Resident #001's empty bedroom, the resident's bed, identified with a specific number, was observed along with a stripped Pressure Pedic by Waterloo mattress, identified with the same number as the bed. One short bed rail was observed lying on the mattress and a second shorter bed rail was observed raised at the head of the bed (facing the window). A large dark stain measuring approximately 20cm by 10cm was observed on the mattress at the edge of the bed, close to the foot of the bed. Below the large dark stain, a gray rigid plastic plate with rounded corners measuring 10cm in width and extending out by 3cm was observed (identified as a "rail deflector"). A small amount of dried blood was observed on the rail deflector as well as on the bed frame adjacent to the rail deflector. The inspector observed the entire bed frame in the presence of PSW #106, Environmental Services Staff #109 and the Environmental Services Supervisor and discovered three other rail deflectors screwed to the bed frame (two per side); all extended out by 3cm and one was ripped presenting with sharp edges, hanging on the outside of the bed frame (facing the washroom).

In a review of Resident #001's health record, it was documented that the resident was admitted to the home in May 2013 with several medical conditions including heart conditions and diabetes. In the most recent plan of care, it was indicated that the resident was at risk for impaired skin integrity related to diabetes and that staff needed to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. According to the Resident's Medication Administration Record, the resident was taking an anticoagulant daily which according to the

manufacturer's documentation, increases risk of bleeding. In a progress note dated a specific date in December 2015 it was documented that the coroner had been in and completed an investigation and determined cause of death to be a large blood loss from an accidental vascular laceration to a specific limb. It is to be noted that a discrepancy in the location of the laceration was observed by the inspector; the coroner documented that the laceration was on a specific limb, and in the progress note it was documented that the laceration was on a different limb. In discussion with the DOC, she indicated that she was present with the coroner during the assessment of the body and recalled the laceration being on a specific area of a specific limb.

The most recent assessment indicated that the Resident had mild cognitive impairment, was independent with activities of daily living including transferring in and out of bed and mobilized with a mobility aide. It was also noted that the Resident did not require bed rails however in the Daily Flow Sheet completed by the PSWs, it was documented that one bed rail was raised on all shifts for 20 days prior to the accidental death. No other documentation explained the recent need for use of a bed rail.

During an interview with PSW #111, she indicated that one bed rail was kept raised on Resident #001's bed, facing the washroom. She described the bed rail, as a half bed rail covering the center of the bed, leaving space at the head of the bed and at the foot of the bed to allow the resident space to exit the bed if required. She further indicated that Resident #001 always entered and exited the bed independently using the side facing the window and that no bed rails were raised on that side. The PSW later indicated that the half bed rail facing the washroom was kept raised on all shifts.

PSW #106 and RPN #105 both indicated that Resident #001 had significant vascular disease to legs, ambulated independently with use of a mobility aide and due to fatigue would rest on a chair near the nursing station before heading to his/her bedroom when leaving the dining room after meals.

Environmental Service Staff #109 indicated that all full bed rails were removed over a year ago on all beds in the home including Resident #001's bed and were replaced with shorter bed rails. He indicated that the rigid plastic rail deflectors that were installed on the bed frames were used to prevent the full bed rails from hitting the mattress, when the rails were raised. He added that the rail deflectors no longer had a purpose. Staff #109 further indicated that the four rail deflectors on this bed and other beds would be removed; he immediately unscrewed the two bolts holding the rail deflectors in place and removed them.

During an interview with the DOC, she indicated that she had not yet conducted a case review with staff to determine if any actions could have been taken to correct this situation. She further added that she planned on debriefing with staff the following week.

In a review of a specific bed Instructions and Warranty manual provided by the Environmental Services Supervisor (ESS), it was documented that at least once a year, the home should inspect and test all features of the bed.

During an interview with the ESS, he indicated that he had not been requested to examine any of Resident #001's equipment or furnishing following the incident. He indicated that Resident #001 was assigned bed a specific bed with two full bed rails upon admission in May 2013. He further indicated that the home replaced all full bed rails in April and May 2014 with half bed rails (Assist Rails U Bracket Clamp Epoxy PR) to reduce the risk of bed-related resident entrapment as per Ministry recommendation. The ESS indicated that after the installation of the new bed rails, an inspection of the new bed rail system was not conducted for Resident #001's bed or any other bed in the home. He later indicated that it was the responsibility of each staff in the home to check on, a daily basis, safety of equipment and furnishings and to report any issues to the Environmental Services Department for repair. He indicated that it was not the home's practice to conduct preventative maintenance on any of the bed system. He confirmed that the last bed system assessment was conducted in January 2013 to review entrapment risks related to bed rails, and that none were done after that date. The ESS then indicated that all rail deflectors would be immediately removed from all bed systems.

The role of the rail deflector in the death of Resident #001 is inconclusive. [s. 90. (2) (a)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan that sets out, the planned care for Resident #001 who was on anticoagulant therapy & associated risks; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care.

Resident #001 was admitted to the home in May 2013 with several medical conditions including heart conditions and diabetes. According to the most recent assessment (Nov 2015), Resident #001 was independent with all activities of daily living including transfers, toileting and walking on & off the unit with a mobility aide, with a fall on a specific date in December 2015.

In a review of the resident's Medication Administration Record (MAR), it was documented that Resident #001 was taking a daily anticoagulant for a specific heart condition. As per the resident's health record, it was documented that upon admission the home's physician had discontinued one anticoagulant and continued with another anticoagulant medication.

During an interview with PSW #106 she indicated that the Resident had good skin integrity except for a significant vascular issue on one limb. She then indicated that the

Resident often complained of fatigue, sore feet and required to rest when walking from the dining room to his/her bedroom.

In a review of the resident's most recent plan of care (December 2015), information regarding the risk of bleeding related to anticoagulant therapy was not found. On an archived care plan, it was documented on a specific date in May 2014 under section: "Risk of bleeding due to bruising, injury related to anticoagulant use" to protect Resident #001 from injury, avoid sudden, jarring, bumps when transferring or providing care.

RPN #103 indicated that Resident #001's care plan included risks of anticoagulant therapy when she was taking one specific anticoagulant medication and once it was discontinued and started on a different anticoagulant medication, the information was removed from the care plan. The RPN indicated that the risk of bleeding were less with the different anticoagulant medication, however in his view, the plan of care should still have included risk of bleeding due to vascular disease on the resident's limbs.

During an interview with the DOC, she indicated that it was the home's expectation that registered staff be knowledgeable about Resident #001's medication regime and ensure that the written plan of care, included goals the care related to anticoagulant therapy was intended to achieve; and clear directions to staff and others who provided direct care to this resident related to risks when on anticoagulant therapy. [s. 6. (1)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of Resident #001's so that their assessments are integrated, consistent with and complement each other.

Resident #001 was admitted to the home in May 2013 with several medication conditions including heart conditions and diabetes. According to the most recent assessment (November 2015), Resident #001 was independent with all activities of daily living including transfers, toileting and walking on & off the unit with a mobility aide. There was no indication of unsteady gait, vertigo/dizziness or reported falls in the past 180 days during that assessment.

Upon review of a Critical Incident Report (CIR) submitted by the home on a specific date in December 2015, it was documented that Resident #001 was found in a pool of blood that same morning with no vital signs. In the description of the incident, the Director of Care documented that the Resident had no falls in the past 180 days.

In a review of the Resident's progress notes, a note dated approximately two weeks prior to the incident, it was indicated that Resident #001 had fallen and upon assessment, RPN #105 had documented that the resident grimaced and pointed at a specific area on a limb that was slightly larger than the compared limb. It was also noted that the resident complained of dizziness with a blood pressure lower than the resident's usual blood pressure. A note from the physiotherapist indicated on the day following the fall, that upon assessment, the the specific area on the limb was slightly swollen with discomfort on moving or walking and that when observed walking the resident had to stop due to dizziness. The physiotherapist noted that dizziness was a concern and possibly caused the fall the previous day and recommended that staff supervise gait and transfers and made the nurse aware of change in care.

In a review of the resident's most recent plan of care (December 2015) it was documented that Resident #001 could weight bear and transfer without assistance and to provide assistance when needed. It was also documented that the resident was independent with the use of a mobility aide and to observe ambulation for endurance and steadiness. There was no information related to the resident's recent fall, including recommendations from the physiotherapist to supervise the resident while walking and transferring due to dizziness.

During interviews with PSW #104, PSW #106, PSW #111, they indicated that they were not aware of any falls that Resident #001 would have had in the recent months. They indicated that the resident ambulated independently with a mobility aide slowly and required resting when returning from the dining room. RPN #103 did not think the Resident had any recent falls, then returned later to inform the Inspector that it had been documented in a progress note on a specific date in December 2015 that the resident had fallen. He indicated that a post-fall assessment could not be found in the resident's health record and that the plan of care did not reflect this change in condition.

During an interview with RPN #105, she indicated that she had completed a post-fall assessment and showed the Inspector a blank Incident/Fall/Near Miss Report, when the resident reported a fall to her on a specific date in December 2015. She indicated that once completed, she forwarded it to the Director of Care for her to follow-up and indicated she was unsure where the form was kept after that, as it could not be found in the resident's health record.

During an interview with the Director of Care, she indicated that after reviewing the post-fall assessment (completed Incident/Fall/Near Miss Report), she forwarded it to the

home's kinesiologist for follow-up. She indicated that she thought that the post-fall assessment was kept in the resident's health record, added that all residents' falls were tracked by the home's kinesiologist.

Kinesiologist #108 indicated to Inspector #545 that she had received a completed Incident/Fall/Near Miss Report on a specific date in December 2015, and immediately requested a physiotherapy referral to review. She indicated that she kept the completed Incident/Fall/Near Miss Report on file in her office for tracking purposes, and showed it to the Inspector. She further indicated that the physiotherapist had assessed Resident #001 one day after receiving the referral and had recommended that staff supervise Resident#001 during gait and transfers due to dizziness that might have been the cause to the fall on a specific date in December 2015. A hand-written note attached to the Incident/Fall/Near Miss Report indicated that there was a decrease in the resident's usual blood pressure and the list of medications was attached, highlighting the resident's daily medications used to treat hypertension. The kinesiologist later indicated that the physiotherapist was a contracted employee and did not have access to the care plan; therefore it was the responsibility of the nursing staff to update the care plan with the information provided by the physiotherapist.

As such, the registered staff, kinesiologist, physiotherapist and DOC who were involved in the different aspects of care did not collaborate with each other when Resident #001's fell on a specific date in December 2015, so that their assessments were integrated, consistent with and complement each other. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care that sets out, the planned care for residents who are on any anticoagulant therapy and associated risks; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care, to be implemented voluntarily.

Issued on this 27th day of January, 2016
Amended on this 5th day of April, 2016

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ANGELE ALBERT-RITCHIE (545)
Inspection No. / No de l'inspection :	2016_284545_0002
Log No. / Registre no:	036487-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 11, 2016 Amended: April 5, 2016, following discussions with the home on March 9, 2016, regarding some wording changes in the Grounds
Licensee / Titulaire de permis :	THE CORPORATION OF THE CITY OF CORNWALL 1900 Montreal Rd., CORNWALL, ON, K6H-7L1
LTC Home / Foyer de SLD :	GLEN-STOR-DUN LODGE 1900 MONTREAL ROAD, CORNWALL, ON, K6H-7L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Norm Quenneville

To THE CORPORATION OF THE CITY OF CORNWALL, 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. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall develop and implement procedures to ensure that resident's bed systems are kept in good repair, and maintained at a level that meets manufacture specifications, at a minimum, for achieving compliance with O. Reg. 79/10, section 90 (2) (a) through the following actions:

1. Conduct a safety inspection of all resident's bed system in the home;

2. Remove all rail deflectors and other unnecessary accessories or parts on resident's bed system that could potentially pose serious risk to residents;

3. Develop procedures to include regular safety inspection of residents' bed system; and

4. Implement a schedule for regular preventative maintenance for residents' bed systems.

Grounds / Motifs :

1. The licensee failed to ensure that procedures are developed and implemented to ensure that, electrical and non-electrical equipment, such as resident's bed systems are kept in good repair, and maintained at a level that meets manufacturer specifications, at a minimum.

Upon review of a Critical Incident Report (CIR) submitted by the home on a specific date in December 2015, it was documented that Resident #001 was found lying in a pool of blood that same morning with no vital signs. A note in the CIR indicated that upon the coroner's assessment, it was determined that the cause of death was due to a large blood loss from an accidental vascular laceration to a specific limb in the setting of anticoagulant therapy.

In a review of the death certificate with a specific date in December 2015, signed by the coroner, it was documented that the resident's death was caused by an accidental cut injury to a specific limb at site of a vascular disease to edge of bed.

During an observation of Resident #001's empty bedroom, the resident's bed, identified with a specific number, was observed along with a stripped Pressure Pedic by Waterloo mattress, identified with the same number as the bed. One short bed rail was observed lying on the mattress and a second shorter bed rail was observed raised at the head of the bed (facing the window). A large dark

stain measuring approximately 20cm by 10cm was observed on the mattress at the edge of the bed, close to the foot of the bed. Below the large dark stain, a gray rigid plastic plate with rounded corners measuring 10cm in width and extending out by 3cm was observed (identified as a "rail deflector"). A small amount of dried blood was observed on the rail deflector as well as on the bed frame adjacent to the rail deflector. The inspector observed the entire bed frame in the presence of PSW #106, Environmental Services Staff #109 and the Environmental Services Supervisor and discovered three other rail deflectors screwed to the bed frame (two per side); all extended out by 3cm and one was ripped presenting with sharp edges, hanging on the outside of the bed frame (facing the washroom).

In a review of Resident #001's health record, it was documented that the resident was admitted to the home in May 2013 with several medical conditions including heart conditions and diabetes. In the most recent plan of care, it was indicated that the resident was at risk for impaired skin integrity related to diabetes and that staff needed to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. According to the Resident's Medication Administration Record, the resident was taking an anticoagulant daily which according to the manufacturer's documentation, increases risk of bleeding. In a progress note dated a specific date in December 2015 it was documented that the coroner had been in and completed an investigation and determined cause of death to be a large blood loss from an accidental vascular laceration to a specific limb. It is to be noted that a discrepancy in the location of the laceration was observed by the inspector; the coroner documented that the laceration was on a specific limb, and in the progress note it was documented that the laceration was on a different limb. In discussion with the DOC, she indicated that she was present with the coroner during the assessment of the body and recalled the laceration being on a specific area of a specific limb.

The most recent assessment indicated that the Resident had mild cognitive impairment, was independent with activities of daily living including transferring in and out of bed and mobilized with a mobility aide. It was also noted that the Resident did not require bed rails however in the Daily Flow Sheet completed by the PSWs, it was documented that one bed rail was raised on all shifts for 20 days prior to the accidental death. No other documentation explained the recent need for use of a bed rail.

During an interview with PSW #111, she indicated that one bed rail was kept raised on Resident #001's bed, facing the washroom. She described the bed rail, as a half bed rail covering the center of the bed, leaving space at the head of the bed and at the foot of the bed to allow the resident space to exit the bed if required. She further indicated that Resident #001 always entered and exited the bed independently using the side facing the window and that no bed rails were raised on that side. The PSW later indicated that the half bed rail facing the washroom was kept raised on all shifts.

PSW #106 and RPN #105 both indicated that Resident #001 had significant vascular disease to legs, ambulated independently with use of a mobility aide and due to fatigue would rest on a chair near the nursing station before heading to his/her bedroom when leaving the dining room after meals.

Environmental Service Staff #109 indicated that all full bed rails were removed over a year ago on all beds in the home including Resident #001's bed and were replaced with shorter bed rails. He indicated that the rigid plastic rail deflectors that were installed on the bed frames were used to prevent the full bed rails from hitting the mattress, when the rails were raised. He added that the rail deflectors no longer had a purpose. Staff #109 further indicated that the four rail deflectors on this bed and other beds would be removed; he immediately unscrewed the two bolts holding the rail deflectors in place and removed them.

During an interview with the DOC, she indicated that she had not yet conducted a case review with staff to determine if any actions could have been taken to correct this situation. She further added that she planned on debriefing with staff the following week.

In a review of a specific bed Instructions and Warranty manual provided by the Environmental Services Supervisor (ESS), it was documented that at least once a year, the home should inspect and test all features of the bed.

During an interview with the ESS, he indicated that he had not been requested to examine any of Resident #001's equipment or furnishing following the incident. He indicated that Resident #001 was assigned bed a specific bed with two full bed rails upon admission in May 2013. He further indicated that the home replaced all full bed rails in April and May 2014 with half bed rails (Assist Rails U Bracket Clamp Epoxy PR) to reduce the risk of bed-related resident

entrapment as per Ministry recommendation. The ESS indicated that after the installation of the new bed rails, an inspection of the new bed rail system was not conducted for Resident #001's bed or any other bed in the home. He later indicated that it was the responsibility of each staff in the home to check on, a daily basis, safety of equipment and furnishings and to report any issues to the Environmental Services Department for repair. He indicated that it was not the home's practice to conduct preventative maintenance on any of the bed system. He confirmed that the last bed system assessment was conducted in January 2013 to review entrapment risks related to bed rails, and that none were done after that date. The ESS then indicated that all rail deflectors would be immediately removed from all bed systems. (545)

The role of the rail deflector in the death of Resident #001 is inconclusive.
[s. 90. (2) (a)]

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 29, 2016

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 11th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Angele Albert-Ritchie

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