Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 12, 2015	2015_226192_0008	001762-15	Critical Incident System

Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North P.O. Box 460 Tavistock ON N0B 2R0

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

HILLTOP MANOR CAMBRIDGE
42 ELLIOTT STREET CAMBRIDGE ON N1R 2J2

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

DEBORA SAVILLE (192)

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): February 3, 4, 2015

This Critical Incident inspection was conducted concurrently with Critical Incident Inspection 000138-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Administrator, Director of Care, Registered Practical Nurse, Personal Support Workers, Director of Quality Outcomes and Director of Resident Care.

The inspector also reviewed written statements, policies, medical records, call bell reports, training records, incident reports, memos, Fall Committee meeting minutes and observed the resident's room.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Resident #001 was identified to be at risk for falls, having sustained falls from bed.

Minimum Data Set (MDS) assessments completed in 2014 and 2015 identified that resident #001 used bed rails for mobility or transfers. Interview with the Executive Director confirmed the use of bed rails by resident #001.

Interview confirmed that resident #001 had not been assessed for bed safety in relation to the use of a bed rail and that resident #001's bed had not been assessed for entrapment risk.

Record review and interview identified that resident #001 had sustained an increase in the number of falls from bed. No new interventions were introduced.

The plan of care indicated that resident #001 required a device to be in place to alert staff of imminent fall risk.

In 2015 resident #001 was found lying partially on the floor, by a Personal Support Worker.

Statements recorded following the incident by a registered nurse identified that during assessment the resident moved to the floor and was observed to have a mark in a specified location.

The licensee failed to ensure resident #001 was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs when they failed to assess the residents safety in bed with bed rails in place, failed to initiated additional interventions when it was identified that the resident had an increase in falls from bed, and removed the device that may have alerted staff to the resident's activity in bed, from the residents use, without having completed an assessment of the resident. [s. 3. (1) 4.]

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for resident #001 indicated that a device was to be in place as the resident would attempt to self transfer resulting in falls.

Documentation review and interview confirmed that resident #001 had sustained falls from bed in 2015.

On a specified date in 2015 resident #001 was found lying partially on the floor. Interview with the Executive Director and Administrator confirmed that the device was not in place at the time of the fall to alert staff.

The licensee failed to ensure that care set out in the plan of care was provided to resident #001 as specified in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of

care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Documentation review and interview with the Director of Care confirmed that resident #001 had sustained an increased frequency of falling in 2015.

The plan of care was reviewed and identified that no new interventions were put in place in spite of resident #001 having an increase in falls in 2015. Staff documented on a specified date that there had been an increase in falls.

A progress note completed in 2015 indicated that it had been identified that the resident would benefit from the addition of a second device to prevent injury from falls. A progress note completed in 2015 indicated that the second device had been obtained and was to be used for the resident. Interview identified that the second device was initiated at this time as the first device had been removed from resident #001's use, for another resident of the home.

Further review of the plan of care and Kardex confirmed that the use of the second device was not included in the plan of care for resident #001 and that use of the first device remained an intervention for the resident under risk of falls in the plan of care.

The licensee failed to reassess resident #001 and review and revise the plan of care when the resident's care needs changed in 2015. [s. 6. (10) (b)]

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. 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 ensure that where bed rails are used, the resident has 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.

In 2015 resident #001 was found partially out of their bed.

Minimum Data Set assessments completed in 2014 and 2015 identified that the resident used a bed rail for mobility or transfer.

Interview with the Executive Director confirmed that resident #001 and all other residents of the home had not had their bed systems evaluated in accordance with evidence-based practices. In addition, resident #001 had not been assessed for their safety in a bed with bed rails in place.

Resident #001 had sustained previous falls from bed in 2015.

The licensee failed to ensure that where bed rails are used, the resident has been assessed and their bed system evaluated to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act.

A) The home's policy titled Bed Rails (Siderails) reference number 005530.00 dated October 28, 2014 indicated that the bed system will be evaluated for safety and to ensure elimination of risk of entrapment.

O. Reg 79/10 s. 15(1) (a) states that every licensee of a long term care home shall ensure that where bed rails are used, the resident is 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.

The licensee's policy failed to identify the need to assess the residents safety where bed rails are used.

B) The home's policy titled Bed Rails (Siderails) reference number 005530.00 dated October 28, 2014 indicated that a bed rail would be considered a Personal Assistance Services Device (PASD) if the rail limits the residents ability to get out of bed.

The Long Term Care Homes Act 2007, S.O. 2007, chapter 8, section 33(2) defines a

personal assistance services device (PASD) as being a device used to assist a person with a routine activity of living.

Resident #001 was identified in Minimum Data Set (MDS) assessments completed in 2014 and 2015 to require the use of a bed rail for mobility or transferring. The bed rail used for resident #001 would be considered a PASD. Section 33 of the LTCHA 2007 would apply if the PASD in use had the effect of limiting or inhibiting a resident's freedom of movement and the resident was not able to physically or cognitively release themself from the PASD.

The homes policy failed to clearly represent the legislation when it indicated a bed rail would be considered a PASD only when it limited a residents ability to get out of bed. [s. 8. (1) (a)]

2. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

The home's policy titled Bed Rails (Siderails), reference number 005530.00 effective October 28, 2014 and introduced in the home on January 9, 2015 indicated to assess the resident's need for use of bed rails.

On page 2, the policy indicated to document the reason, number of bed rails, type of bed rail being used in the resident's plan of care in a consistent manner and place task on Point of Care.

The plan of care for resident #001 identified that the resident was at risk of falls. Interventions identified included access to the call bell and use of a device.

Minimum Data Set assessments completed in 2014 and 2015 identified the use of bed rails for mobility or transfers.

Resident #001 sustained falls from bed in 2015 and was found, on a specified date in 2015, lying partially on the floor.

Record review and interview with the Executive Director and Director of Care confirmed that resident #001 had not been assessed for the use of bed rails.

Record review and interview with the Director of Resident Care and the Director of Resident Quality Outcomes confirmed that the use of bed rails had not been included on resident #001's plan of care. Interview with the Director of Care confirmed that the use of bed rails had not been included as a task on Point of Care for resident #001.

The licensee failed to ensure that the home's policy titled Bed Rails was complied with for resident #001. [s. 8. (1) (b)]

3. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

The home's policy titled Fall Prevention and Management Program, reference number 005190.00 effective September 10, 2014 indicated:

A) Registered Staff will ensure a thorough multidisciplinary investigation through a falls conference "huddle" with all team members available, reviewing triggering events and preventative measures. The plan of care is to be updated following the conference.

In 2015 a progress note related to a fall for resident #001 indicated that a "huddle" had occurred after the resident had been fallen. Interventions discussed at the post fall huddle included adding a device to minimize risk of injury.

Record review and interview with the Director of care confirmed that the device was not made available to staff until four days after the huddle and that the plan of care was not updated to include the use of the device for resident #001.

B) Registered staff will complete a Falls Incident Report through Risk Management on Point Click Care (PCC) ensuring all sections of the tool are completed.

Record review and interview with the Director of Care confirmed that Falls Incident Reports completed for resident #001 on nine specified dates in 2014 and 2015 failed to have all of the sections of the Falls Incident Report completed.

The licensee failed to ensure that the home's policy titled Fall Prevention Management Program was complied with. [s. 8. (1) (b)]

4. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

The home's policy titled Multidisciplinary Documentation, reference number 009060.00, dated as effective May 20, 2012 stated that Personal Support Worker staff will document on Point of Care as close to the time of completion of a task as possible. Do not bulk chart for tasks. Timed tasks must be documented as close to the time of the event as possible.

Resident #001 was identified under tasks to require monitoring and to have a device in place.

Documentation review confirmed by the Director of Care identified that bulk charting of required monitoring was completed on specified dates .

Interview with the Executive Director, Director of Care, Administrator and a Registered Practical Nurse confirmed that resident #001 did not have the device in place on a specified date when it had been recorded that monitoring of the device had been completed.

The licensee failed to ensure that the home's policy titled Multidisciplinary Documentation was complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the plan, policy, protocol, procedure, strategy or system is complied with., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in falls prevention and management.

Interview with the Director of care confirmed that training related to fall prevention and management is included in mandatory training provided by the home.

Interview with Director of Resident Quality Outcomes who had been responsible for the tracking of training for 2014 confirmed that 24 of 230 staff (10.4%) working in the home had not received the mandatory training related to fall prevention and management.

The licensee failed to ensure that all staff who provide direct care to residents received training on falls prevention and management. [s. 221. (1) 1.]

Issued on this 17th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192)
Inspection No. / No de l'inspection :	2015_226192_0008
Log No. / Registre no:	001762-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 12, 2015
Licensee / Titulaire de permis :	PEOPLECARE Inc. 28 William Street North, P.O. Box 460, Tavistock, ON, N0B-2R0
LTC Home / Foyer de SLD :	HILLTOP MANOR CAMBRIDGE 42 ELLIOTT STREET, CAMBRIDGE, ON, N1R-2J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Blair Philippi

To PEOPLECARE Inc., 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that every resident of the home is cared for in a manner consistent with his or her needs.

Grounds / Motifs :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Resident #001 was identified to be at risk for falls, having sustained falls from bed.

Minimum Data Set (MDS) assessments completed in 2014 and 2015 identified that resident #001 used bed rails for mobility or transfers. Interview with the Executive Director confirmed the use of bed rails by resident #001.

Interview confirmed that resident #001 had not been assessed for bed safety in relation to the use of a bed rail and that resident #001's bed had not been assessed for entrapment risk.

Record review and interview identified that resident #001 had sustained an increase in the number of falls from bed. No new interventions were introduced.

The plan of care indicated that resident #001 required a device to be in place to alert staff of imminent fall risk.

In 2015 resident #001 was found lying partially on the floor, by a Personal Support Worker.

Statements recorded following the incident by a registered nurse identified that during assessment the resident moved to the floor and was observed to have a mark in a specified location.

The licensee failed to ensure resident #001 was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs when they failed to assess the residents safety in bed with bed rails in place, failed to initiated additional interventions when it was identified that the resident had an increase in falls from bed, and removed the device that may have alerted staff to the resident's activity in bed, from the residents use, without having completed an assessment of the resident. (192)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that where a resident is identified to require a bed sensor pad, the pad is available as set out in the plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for resident #001 indicated that a device was to be in place as the resident would attempt to self transfer resulting in falls.

Documentation review and interview confirmed that resident #001 had sustained falls from bed in 2015.

On a specified date in 2015 resident #001 was found lying partially on the floor. Interview with the Executive Director and Administrator confirmed that the device was not in place at the time of the fall to alert staff.

The licensee failed to ensure that care set out in the plan of care was provided to resident #001 as specified in the plan of care. (192)

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that where bed rails are used;
i) the resident is assessed and
ii) his or her bed system is evaluated in accordance with evidence-based practices to minimize risk to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident has 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.

In 2015 resident #001 was found partially out of their bed.

Minimum Data Set assessments completed in 2014 and 2015 identified that the resident used a bed rail for mobility or transfer.

Interview with the Executive Director confirmed that resident #001 and all other residents of the home had not had their bed systems evaluated in accordance with evidence-based practices. In addition, resident #001 had not been assessed for their safety in a bed with bed rails in place.

Resident #001 had sustained previous falls from bed in 2015.

The licensee failed to ensure that where bed rails are used, the resident has been assessed and their bed system evaluated to minimize risk to the resident. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 12th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE

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