Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 1, 2015	2015_226192_0033	009302-15	Follow up

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

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

MAPLE MANOR NURSING HOME
73 BIDWELL STREET TILLSONBURG ON N4G 3T8

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 Follow up inspection.

This inspection was conducted on the following date(s): May 14 and 15, 2015

This inspection was completed to follow-up on compliance orders #003 and #006 from the Resident Quality Inspection (L-001836-15)with compliance dates of May 4, 2015.

This inspection was conducted concurrently with Critical Incident Inspection 009447-14 and Complaint Inspection 003926-15.

During the course of the inspection, the inspector(s) spoke with the Operations Manager, Controller/Assistant Administrator, Resident Assessment Instrument (RAI) Coordinator, registered nurses, registered practical nurses, personal support workers, clerical support staff, a housekeeping aide and residents.

The inspector toured the home, observed the use of bed rails, reviewed medical records, assessments, policy and procedure, maintenance records, a third party bed assessment and information provided to residents in the admission package.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 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 O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Administrator works regularly in that position, on site for at least 35 hours per week.

Previously issued as a compliance order March 16, 2015 with a compliance date of May 4, 2015.

Interview conducted on May 14, 2015, with the Operations Manager for Maplewood Nursing Homes Limited which was listed as the licensee for Maple Manor identified that the designated Administrator of the home was currently absent and had not worked routinely in the home for the past three years.

Interview with Controller/Assistant Administrator, housekeeping staff, personal support workers and registered staff in the home identified that the person most responsible for the home was the Operations Manager.

The Long-term Care Homes Act 2007 s.o.2007, chapter 8 s. 70(2)(a) states that the Administrator shall be in charge of the home and be responsible for its management.

Interview with the Operations Manager who was also the Administrator for Cedarwood Village, another Long-term Care Home for whom Maplewood Nursing Homes Limited was the licensee, confirmed that they are in attendance at the home for only two days per week and that the Assistant Administrator was in the home five days each week.

Interview with the Controller/Assistant Administrator identified that their primary role was

as a Controller for Maplewood Nursing Homes Limited with fifty percent of their salary coming from funding provided to Maple Manor Nursing Home and fifty percent of their salary coming from funding provided to Cedarwood Village. In addition, the Controller/Assistant Administrator identified that while their primary focus was on duties as the Controller, they did address concerns that arise related to Maple Manor Nursing Home.

When asked for a list of managers in the home, clerical staff at the reception area provided the Maple Manor Nursing Home process for obtaining information, raising concerns and lodging complaints, that was provided to new residents at the time of admission. No Administrator was identified on this document. For issues/concerns that were not addressed to the complainants satisfaction individuals were directed to contact the Operations Manager. It was noted that a second document was provided that identified the Administrator. The person listed was the same person the Operations Manager and Controller identified to be absent from the home.

The licensee failed to ensure that the home's Administrator works regularly in that position and was on site for at least 35 hours per week. [s. 212. (1)]

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. 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 was assessed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

The home had established a policy titled Resident Bed Rail Risk Assessment for Entrapment, dated April 20, 2015 that required Registered Nursing staff to complete Bed Rail Risk Assessments on admission, with a significant change in health status, quarterly, with a change to existing bed rails, a change in mattress or altering of a surface.

Record review and interview confirmed that 23 of the residents in the home had been assessed for bed rail risk in May 2015. Interview with the registered staff member completing the assessments identified that they had received no training on risks associated with bed rail use, on the use of the assessment tool and indicated they had not seen the policy related to this assessment.

Observation of the resident in a specified room, with the registered staff member identified the resident to be in bed with an assist rail in the up position on the resident's left side and an assist rail in the down position at the center of the bed on the resident's right side. A telephone was positioned at the center of the dresser, to the right of the resident. In order to reach the telephone, the resident would have to reach behind the raised assist rail, increasing the risk of entrapment in the rail. The bed rail to the left of the resident was identified to be loose and provided an entrapment risk at the end of the rail. The resident in the bed had not been assessed using the Bed Rail Risk Assessment for Entrapment. The 2015 bed assessment completed by Joerns identified the bed to have failed entrapment risk at zone 2 and recommended monthly tightening of the bed rails.

Observation of the resident in a specified room, with the registered staff member identified the resident to be in a high low bed at it's lowest position with two assist rails positioned at the center of the bed in the down position. It was confirmed that the resident was at risk of falls. The bed rails were observed to be loose and presented a hazard for resident entrapment as well as a risk if the resident were to go over the rail. The resident in the bed had not been assessed using the Bed Rail Risk Assessment for Entrapment. The 2015 bed assessment completed by Joerns identified the bed to have failed entrapment risk at zone 2 and recommended monthly tightening of the bed rails.

Residents in a specified room were identified during the Resident Quality Inspection (RQI) initiated February 9, 2015 to be at risk related to bed rail safety. Observation on May 15, 2015 identified that bed rails were in use on both beds. The 2015 Joerns assessment for entrapment identified that bed A had failed in zones 2 and 4 and that bed B had failed in zones 2, 4 and 7. No Bed Rail Risk Assessment for Entrapment was completed for either resident.

In May 2015 both residents in a specified room were observed in bed with bed rails in the raised position and beds in an elevated position. The resident in bed B had been identified to be at risk of entrapment during the RQI initiated on February 9, 2015. The 2015 Joerns assessment for entrapment identified that bed B had failed zones 2 and 4 and bed A had failed zones 2 and 4. No Bed Rail Risk Assessment for Entrapment was completed for either resident.

In May 2015 the resident in a specified room was observed in bed on a specified surface, bed elevated with two full bed rails in the up position. Record review identified that the surface had been applied on a specified date. The resident was assessed using the Bed Rail Risk Assessment for Entrapment tool and identified that the resident required two full bed rails and was at high risk. Interview with the registered staff member conducting the assessment identified that they were unaware of the risk of entrapment associated with the use of the specified surfaces and confirmed that no interventions were put in place to minimize the risk to the resident.

During record review for resident #001 it was identified that on a specified date in 2014 the bed alarm sounded and the resident was found with their head and shoulders off the bed and resting on the ground against the dresser. The same resident was found three weeks later with the left side of head on the floor, body remaining in bed. The head had gone between the rail and the head of the bed. Interview with the Operations Manager confirmed he was unaware of this potential entrapment for resident #001.

The licensee failed to ensure that where bed rails were used the resident was assessed in accordance with evidence-based practices to minimize risk to the resident. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Previously issued as a compliance order on March 16, 2015 with a compliance date of

May 4, 2015.

The home provided documentation of the checking of beds with bed rails conducted on March 17, 18, 23 and 26, 2015 however it was unclear what was done for each of the beds checked at this time.

In 2015 bed assessments were conducted by Joerns and identified that 85 percent of the beds tested failed one or more zones of entrapment where bed rails were in use. Of the 12 beds that passed all zones of entrapment the company recommended that bed rails be tightened monthly on eight of the beds. Four beds were not tested for entrapment, one bed had no bed rails in place, one related to use of a specified surface and two because only one bed rail was in place. It was noted that beds in room 120, where bed rails were observed to be in use, were not included in the Joerns assessment. Under Additional notes on the assessment, it was recommended that 51 percent of the beds have one or both bed rails removed and 41 percent required tightening of the bed rails monthly.

Interview with the Operations Manager identified that they were not aware of maintenance to beds with bed rails initiated in relation to the 2015 assessment. Documentation provided indicated maintenance installed a safety piece on bed rails, checked bed rails and checked for old style mattresses prior to the 2015 assessment, but failed to identify what action was taken for each bed checked. Documentation did not support that action had been taken after the 2015 assessment to minimize risk of entrapment in identified zones of entrapment.

Interview with the Operations Manager confirmed that the home was unable to provide evidence of a Preventative Maintenance program related to the monthly tightening of bed rails identified as required for 41 percent of the beds with bed rails assessed in 2015.

Resident's in thirteen specified beds were observed in May 2015 with bed rails in place.

Observation of the resident in a specified room with the registered staff member responsible for conducting Bed Rail Risk Assessment for Entrapment, identified the resident to be in a bed with two full bed rails in the raised position. The registered staff member was unfamiliar with the zones of entrapment. Pressure applied to the mattress at the center of the bed provided a large gap between the bed rail and the mattress, presenting a potential zone of entrapment. The 2015 bed assessment completed by

Joerns identified this bed to have failed entrapment risk at zones 2 and 4 and recommended the removal of the bed rails. Interview with the registered staff member confirmed that a Bed Rail Risk Assessment for Entrapment was conducted for this resident, but did not identify potential risks related to entrapment for this resident and no interventions were in place to minimize the risk of entrapment.

The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 4th day of June, 2015

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

Original report signed by the inspector.

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) :	DEBORA SAVILLE (192)
Inspection No. / No de l'inspection :	2015_226192_0033
Log No. / Registre no:	009302-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 1, 2015
Licensee / Titulaire de permis :	MAPLEWOOD NURSING HOME LIMITED 500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4
LTC Home / Foyer de SLD :	MAPLE MANOR NURSING HOME 73 BIDWELL STREET, TILLSONBURG, ON, N4G-3T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	GEORGE KANIUK

To MAPLEWOOD NURSING HOME LIMITED, 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)

Linked to Existing Order / Lien vers ordre existant: 2015_261522_0005, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Order / Ordre :

The licensee shall ensure that for a home with 97 beds or more the Administrator works regularly in that position, on site at the home for at least 35 hours per week.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's Administrator works regularly in that position, on site for at least 35 hours per week.

Previously issued as a compliance order March 16, 2015 with a compliance date of May 4, 2015.

Interview conducted on May 14, 2015, with the Operations Manager for Maplewood Nursing Homes Limited which was listed as the licensee for Maple Manor identified that the designated Administrator of the home was currently absent and had not worked routinely in the home for the past three years.

Interview with Controller/Assistant Administrator, housekeeping staff, personal support workers and registered staff in the home identified that the person most responsible for the home was the Operations Manager.

The Long-term Care Homes Act 2007 s.o.2007, chapter 8 s. 70(2)(a) states that the Administrator shall be in charge of the home and be responsible for its management.

Interview with the Operations Manager who was also the Administrator for Cedarwood Village, another Long-term Care Home for whom Maplewood Nursing Homes Limited was the licensee, confirmed that they are in attendance at the home for only two days per week and that the Assistant Administrator was in the home five days each week.

Interview with the Controller/Assistant Administrator identified that their primary role was as a Controller for Maplewood Nursing Homes Limited with fifty percent of their salary coming from funding provided to Maple Manor Nursing Home and fifty percent of their salary coming from funding provided to Cedarwood Village. In addition, the Controller/Assistant Administrator identified that while their primary focus was on duties as the Controller, they did address concerns that arise related to Maple Manor Nursing Home.

When asked for a list of managers in the home, clerical staff at the reception area provided the Maple Manor Nursing Home process for obtaining information, raising concerns and lodging complaints, that was provided to new residents at the time of admission. No Administrator was identified on this document. For issues/concerns that were not addressed to the complainants satisfaction individuals were directed to contact the Operations Manager. A second document was provided that identified the Administrator. The person listed was the same person the Operations Manager and Controller identified to be absent from the home.

The licensee failed to ensure that the home's Administrator works regularly in that position and was on site for at least 35 hours per week. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2015

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that where bed rails are used, the resident is assessed in accordance with evidence-based practices to minimize risk to the entrapment risk to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident was assessed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

The home had established a policy titled Resident Bed Rail Risk Assessment for Entrapment, dated April 20, 2015 that required Registered Nursing staff to complete Bed Rail Risk Assessments on admission, with a significant change in health status, quarterly, with a change to existing bed rails, a change in mattress or altering of a surface.

Record review and interview confirmed that 23 of the residents in the home had been assessed for bed rail risk in May 2015. Interview with the registered staff member completing the assessments identified that they had received no training on risks associated with bed rail use, on the use of the assessment tool and indicated they had not seen the policy related to this assessment.

Observation of the resident in a specified room, with the registered staff member identified the resident to be in bed with an assist rail in the up position on the resident's left side and an assist rail in the down position at the center of the bed on the resident's right side. A telephone was positioned at the center of the dresser, to the right of the resident. In order to reach the telephone, the resident would have to reach behind the raised assist rail, increasing the risk of entrapment in the rail. The bed rail to the left of the resident was identified to be loose and provided an entrapment risk at the end of the rail. The resident in the bed had not been assessed using the Bed Rail Risk Assessment for Entrapment. The 2015 bed assessment completed by Joerns identified the bed to have failed entrapment risk at zone 2 and recommended monthly tightening of the bed rails.

Observation of the resident in a specified room, with the registered staff member identified the resident to be in a high low bed at it's lowest position with two assist rails positioned at the center of the bed in the down position. It was confirmed that the resident was at risk of falls. The bed rails were observed to be loose and presented a hazard for resident entrapment as well as a risk if the resident were to go over the rail. The resident in the bed had not been assessed using the Bed Rail Risk Assessment for Entrapment. The 2015 bed assessment completed by Joerns identified the bed to have failed entrapment risk at zone 2 and recommended monthly tightening of the bed rails.

Residents in a specified room were identified during the Resident Quality Inspection (RQI) initiated February 9, 2015 to be at risk related to bed rail safety. Observation on May 15, 2015 identified that bed rails were in use on both beds. The 2015 Joerns assessment for entrapment identified that bed A had failed in zones 2 and 4 and that bed B had failed in zones 2, 4 and 7. No Bed Rail Risk Assessment for Entrapment was completed for either resident.

In May 2015 both residents in a specified room were observed in bed with bed rails in the raised position and beds in an elevated position. The resident in bed B had been identified to be at risk of entrapment during the RQI initiated on February 9, 2015. The 2015 Joerns assessment for entrapment identified that bed B had failed zones 2 and 4 and bed A had failed zones 2 and 4. No Bed Rail Risk Assessment for Entrapment was completed for either resident.

In May 2015 the resident in a specified room was observed in bed on a specified surface, bed elevated with two full bed rails in the up position. Record review

identified that the surface had been applied on a specified date. The resident was assessed using the Bed Rail Risk Assessment for Entrapment tool and identified that the resident required two full bed rails and was at high risk. Interview with the registered staff member conducting the assessment identified that they were unaware of the risk of entrapment associated with the use of the specified surfaces and confirmed that no interventions were put in place to minimize the risk to the resident.

During record review for resident #001 it was identified that on a specified date in 2014 the bed alarm sounded and the resident was found with their head and shoulders off the bed and resting on the ground against the dresser. The same resident was found three weeks later with the left side of head on the floor, body remaining in bed. The head had gone between the rail and the head of the bed. Interview with the Operations Manager confirmed he was unaware of this potential entrapment for resident #001.

The licensee failed to ensure that where bed rails were used the resident was assessed in accordance with evidence-based practices to minimize risk to the resident. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_261522_0005, CO #003;

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, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Previously issued as a compliance order on March 16, 2015 with a compliance date of May 4, 2015.

The home provided documentation of the checking of beds with bed rails conducted on March 17, 18, 23 and 26, 2015 however it was unclear what was done for each of the beds checked at this time.

In 2015 bed assessments were conducted by Joerns and identified that 85 percent of the beds tested failed one or more zones of entrapment where bed rails were in use. Of the 12 beds that passed all zones of entrapment the

company recommended that bed rails be tightened monthly on eight of the beds. Four beds were not tested for entrapment, one bed had no bed rails in place, one related to use of a specified surface and two because only one bed rail was in place. It was noted that beds in room 120, where bed rails were observed to be in use, were not included in the Joerns assessment. Under Additional notes on the assessment, it was recommended that 51 percent of the beds have one or both bed rails removed and 41 percent required tightening of the bed rails monthly.

Interview with the Operations Manager identified that they were not aware of maintenance to beds with bed rails initiated in relation to the 2015 assessment. Documentation provided indicated maintenance installed a safety piece on bed rails, checked bed rails and checked for old style mattresses prior to the 2015 assessment, but failed to identify what action was taken for each bed checked. Documentation did not support that action had been taken after the 2015 assessment to minimize risk of entrapment in identified zones of entrapment.

Interview with the Operations Manager confirmed that the home was unable to provide evidence of a Preventative Maintenance program related to the monthly tightening of bed rails identified as required for 41 percent of the beds with bed rails assessed in 2015.

Resident's in thirteen specified beds were observed in May 2015 with bed rails in place.

Observation of the resident in a specified room with the registered staff member responsible for conducting Bed Rail Risk Assessment for Entrapment, identified the resident to be in a bed with two full bed rails in the raised position. The registered staff member was unfamiliar with the zones of entrapment. Pressure applied to the mattress at the center of the bed provided a large gap between the bed rail and the mattress, presenting a potential zone of entrapment. The 2015 bed assessment completed by Joerns identified this bed to have failed entrapment risk at zones 2 and 4 and recommended the removal of the bed rails. Interview with the registered staff member confirmed that a Bed Rail Risk Assessment for Entrapment was conducted for this resident, but did not identify potential risks related to entrapment for this resident and no interventions were in place to minimize the risk of entrapment.

The licensee failed to ensure that where bed rails were used, steps were taken

to prevent resident entrapment, taking into consideration all potential zones of entrapment. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 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 1st day of June, 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