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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2013	2013_189120_0007	H-002208-12	Follow up

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

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

PEEL MANOR
525 MAIN STREET NORTH, BRAMPTON, ON, L6X-1N9

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

BERNADETTE SUSNIK (120)

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): January 22, 29 & 31, 2013

This visit was to determine compliance with respect to Orders #001 and #002 which were previously issued on October 1, 2012 with respect to bed safety and maintenance of various tub/shower rooms. Order #001 remains outstanding with additional details provided under WN#1. Order #002 has been sufficiently complied with and has been cleared.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Supervisor, maintenance staff, residents and family members.

During the course of the inspection, the inspector(s) toured all of the tub/shower rooms, toured specific resident rooms and observed their bed systems and reviewed the home's bed safety audit reports.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has not ensured that where bed rails are used,

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

The bed safety audits had not been completed for various residents by the date of inspection. The documentation initially presented was incomplete and by January 31, 2013, confirmation on the status of all beds was still pending. The home had suspended their bed rail conversion project and bed safety audits between January 11 -24, 2013 due to a respiratory outbreak.

Approximately 27 residents in beds where air mattresses have been provided have not received the interventions outlined in the home's plan dated October 2012 to mitigate entrapment risks.

A tour of the home was conducted and 4 beds in particular were observed to be non-compliant.

Bed #1 - A bed was observed with split rails engaged and the resident was lying in the bed. The split rails were required to be replaced or removed.

Bed #2 & 3 - Both beds had air mattresses on their frames, each with a large gap at the head or foot of the bed or both. One resident in particular was lying in bed with a split rail up on one side and the mattress was not long enough for their height. No gap fillers had been provided. The resident's family had stuffed a pillow at the foot of the bed in order to keep the resident's feet from falling into the gap. Bed #3 uses full rails to prevent the resident from falling from bed and the family member also reported that the resident's feet often fall into the gap and they had to stuff it with a pillow.

The Director of Care reported that some of the gap fillers were still on order and that others were on site but had not yet been tested with the various beds.

Bed #4 - The bed was observed to have a conventional spring mattress on it's frame, which was not tested to determine if it met Health Canada's guidelines on bed safety. The mattress was not of the correct width or length for the decking of the bed. The mattress was replaced during the visit.

3 out of the 4 requirements issued under Order #001 on October 1, 2012 remain outstanding. A compliance plan to address the issues had been requested and due by October 31, 2012 and was not received until after January 31, 2013. [s. 15. (1) (b)]

Additional Required Actions:

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

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #002	2012_072120_0073	120

Issued on this 21st day of February, 2013

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

B. Scisnik

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

Ministère 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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2013_189120_0007
Log No. / Registre no:	H-002208-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 21, 2013
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF PEEL 10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	PEEL MANOR 525 MAIN STREET NORTH, BRAMPTON, ON, L6X-1N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~RANJIT CALAY~~ James Egan

To THE REGIONAL MUNICIPALITY OF PEEL, 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: 2012_072120_0073, CO #001;

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:

1. Create and implement a policy and procedure that clearly describes the expectations of nursing staff and maintenance staff with respect to ensuring all beds remain safe and in a good state of repair. Specifically the process for reporting disrepair, when residents require a new or different surface, when a resident requires a bed rail or a different bed rail size, bed auditing frequency and when it would be necessary to re-test a bed for entrapment zones. Provide a copy of the policy to the Inspector.
2. Information as to when and how residents and staff will be or have been informed about the home's bed safety policy.
3. An updated summary with respect to the status of residents with therapeutic surfaces and the types of interventions that have been implemented and time frames.
4. A current bed entrapment zone audit report for all resident beds.

The policy and information shall be submitted to Bernadette Susnik, LTC Homes Inspector, either by mail or e-mail to 119 King St. E., 11th Floor, Hamilton, ON, L8P 4Y7 or Bernadette.susnik@ontario.ca by March 29, 2013.

Note: Contact the inspector promptly should a compliance date need to be extended.

Grounds / Motifs :

1. The licensee has not ensured that where bed rails are used,

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

The bed safety audits had not been completed for various residents by the date of inspection. The documentation initially presented was incomplete and by January 31, 2013, confirmation on the status of all beds was still pending. The home had suspended their bed rail conversion project and bed safety audits between January 11-24, 2013 due to a respiratory outbreak.

Approximately 27 residents in beds where air mattresses have been provided have not received the interventions outlined in the home's plan dated October 2012 to mitigate entrapment risks.

A tour of the home was conducted and 4 beds in particular were observed to be non-compliant.

Bed #1 - A bed was observed with split rails engaged and the resident was lying in the bed. The split rails were required to be replaced or removed.

Bed #2 & 3 - Both beds had air mattresses on their frames, each with a large gap at the head or foot of the bed or both. One resident in particular was lying in bed with a split rail up on one side and the mattress was not long enough for their height. No gap fillers had been provided. The resident's family had stuffed a pillow at the foot of the bed in order to keep the resident's feet from falling into the gap. Bed #3 uses full rails to prevent the resident from falling from bed and the family member also reported that the resident's feet often fall into the gap and they had to stuff it with a pillow.

The Director of Care reported that some of the gap fillers were still on order and that others were on site but had not yet been tested with the various beds.

Bed #4 - The bed was observed to have a conventional spring mattress on it's frame, which was not tested to determine if it met Health Canada's guidelines on bed safety. The mattress was not of the correct width or length for the decking of the bed. The mattress was replaced during the visit.

3 out of the 4 requirements issued under Order #001 on October 1, 2012 remain outstanding. A compliance plan to address the issues had been requested and due by October 31, 2012 and was not received until after January 31, 2013. (120)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

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

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

Issued on this 21st day of February, 2013

Signature of Inspector / Signature de l'inspecteur : B. Susnik

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

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