Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

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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
Jul 3, 2015	2015_281542_0009	S-000831-15	Resident Quality Inspection

Licensee/Titulaire de permis

BINGHAM MEMORIAL HOSPITAL
507 8th Avenue PO Box 70 Matheson ON P0K 1N0

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

ROSEDALE CENTRE
507- 8th Avenue P.O. Box 70 Matheson ON P0K 1N0

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

JENNIFER LAURICELLA (542), MARINA MOFFATT (595)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 25 - 29, 2015.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Staff, Registered Dietitian (RD), Activity Staff, Personal Support Workers (PSWS), Residents and Family Members.

Inspectors conducted a walk-through of resident home areas and various common areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed resident health care records and home policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **6 VPC(s)**
- **2 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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living is included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Inspector #595 reviewed the health care record for resident #014. It was identified in the care plan that the resident used two bed rails as a PASD. Inspector observed the resident sleeping in bed with both bed rails raised.

Inspector spoke with S#101, S#102, and S#103 who all confirmed that the resident used two bed rails while in bed as a PASD. Inspector spoke with S#100 who also confirmed that the bed rails were a PASD for this resident. Inspector was also informed by this staff member that the resident had not signed a consent for the bed rails and that the home only obtains consent for restraints, not PASDs. Inspector further reviewed the health care record and could not find a consent signed for the use of the bed rails for resident #014.

During stage one of the inspection, Inspector #542 observed resident #003 in bed with two bed rails in the raised position. Inspector #542 completed a health care record review for resident #003 which indicated on the most current care plan that the resident uses the bed rails as a PASD. Inspector #542 was unable to locate any documentation to support that consent was received for the use of the bed rails. Inspector #542 interviewed S#105 and S#104 who confirmed that resident #003 uses the bed rails as a PASD. Inspector #595 spoke with S#100 who confirmed that the home does not obtain consents for the use of PASDS. [s. 33. (4) 4.]

2. Inspector #595 observed resident #013 in their wheelchair with a PASD in place. Inspector reviewed the resident's care plan which identified that the PASD was to be used to keep the resident in correct positioning. Inspector reviewed the resident's health care record and could not find a consent for the PASD.

Inspector spoke with S#100 who stated that the home does not obtain consent for PASDs, only restraints. [s. 33. (4) 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 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 residents have 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.

On May 26th, 2015, Inspector #542 observed resident #003 in bed with two bed rails in the raised position. Inspector completed a health care record review and was unable to locate any assessments related the residents and their bed system, an evaluation of the bed system, steps taken to prevent entrapment taking into consideration all potential zones and other issues related to the use of bed rails including the height and latch reliability. Inspector #542 spoke with the Director of Care (DOC) who stated that the home has not completed any assessments on the bed systems yet and that residents are not assessed for the use of the bed rails and the bed rails. The DOC also stated that when a resident is admitted to the home, the bed rails are automatically placed in the raised position. [s. 15. (1)]

2. Inspector #595 reviewed the health care record for resident #014. It was identified in the care plan that the resident used two bed rails. On May 27, 2015 the inspector observed resident #014 sleeping in bed with both bed rails raised. Inspector was informed by S#103, S#102, and S#101 that the resident used two bed rails.

Inspector #595 spoke with S#100 who confirmed that the bed rails were a PASD for the resident so that they could turn and reposition in bed. Inspector reviewed the resident's health care binder and completed assessments in PCC and could not locate a bed rail assessment for this resident or an evaluation of their bed system. [s. 15. (1)]

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. 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Inspector #595 reviewed the home's policy 'Weight and Height Audit and Weight Change Protocol' as provided by the Registered Dietitian. The policy indicated that a referral will be made to the Dietitian for unplanned weight loss or inappropriate weight gain at any time during the month. The guidelines for referral are as follows:
- >5% over one month
- >7.5% over three months
- 10% over six months

Inspector reviewed resident #012's health care record. It was identified that the resident had a significant weight loss during a one month period. Inspector spoke with the Registered Dietitian who stated that the resident had not been referred to them by staff at the time of weight loss, rather they noted the weight loss when they were reviewing the resident's profile on PointClickCare (PCC).

Inspector reviewed resident #013's health care record. It was identified that the resident had a significant weight loss during a one month period. Inspector could not locate a progress note or an assessment that identified the resident's weight loss and that a referral had been made to the Registered Dietitian. Inspector spoke with the Registered Dietitian who stated that the resident had not been referred to them by staff at the time of weight loss, rather they noted the weight loss when they were reviewing the resident's profile on PCC. [s. 8. (1) (a),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 to ensure that the "Weight and Height Audit and Weight Change Protocol" is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home completed a nutritional assessment for resident #012 when there was a significant change in the resident's health condition.

Inspector #595 reviewed the health care record for resident #012. It was identified that the resident had a weight loss over a one month period. Inspector reviewed the resident's health care binder, as well as notes and completed assessments in PCC and could not locate any type of dietary/nutritional assessment by the Registered Dietitian. Inspector spoke with the Registered Dietitian who stated that the resident did not receive an assessment at the time of significant weight loss. The RD stated that the resident was not assessed until two months after the weight loss was noted. [s. 26. (4) (a),s. 26. (4) (b)]

2. Inspector #595 reviewed the health care record for resident #013. It was identified that the resident had a weight loss over a one month period. Inspector reviewed the resident's health care binder, as well as notes and completed assessments in PCC and could not locate any type of dietary/nutritional assessment by the Registered Dietitian. Inspector spoke with the Registered Dietitian who stated that the resident did not receive an assessment at the time of significant weight loss however an assessment was completed two months later. [s. 26. (4) (a),s. 26. (4) (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 to ensure that the registered dietitian completes a nutritional assessment for residents #012, #013 and all residents when there is a significant change in the health condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the recreational and social activities program is offered during the evenings and weekends.

During stage one of the inspection, resident #001 and #003 stated that the home did not provide any activities in the evenings or on the weekends. Inspector #542 reviewed the activity calendar for the month of May 2015 and noted that there were no scheduled activities during the evenings or on the weekends. Inspector #542 spoke with S#107, the Activities coordinator, who confirmed that the home does not offer activity programs in the evenings and rarely on the weekends. [s. 65. (2) (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 to ensure that there are recreational and social activities offered during the evenings and weekends, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle is reviewed by the Residents' Council.

On May 27, 2015, Inspector #542 spoke with resident #001 (a member of the Residents' Council) who stated that they do not recall ever reviewing the menu cycle. Inspector #542 spoke with S#107 who confirmed that they have been assisting the Residents' Council for the past four years and during this time they have not reviewed the home's menu cycle. [s. 71. (1) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the menu cycle is reviewed by the Residents' Council, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey and in acting on it's results.

Inspector #542 interviewed resident #001 who stated that at the Residents' Council meetings they have not discussed any type of survey. Inspector #542 then spoke with S#107 who is the appointed assistant to the Residents' Council. They confirmed that for the past four years the home has not looked to the Residents' Council in developing and carrying out the satisfaction survey nor to act on the results of the survey. [s. 85. (3)]

2. The licensee has failed to ensure that the results of the satisfaction survey are documented and made available to the Residents' Council in order to seek the advice of the Council about the survey.

Inspector #542 spoke with the appointed assistant to the Residents' Council who stated that during the past four years the home has not made the results of the survey available to the Residents' Council. Inspector #542 also spoke with resident #001 who attends the meetings and they confirmed that the Residents' Council has not seen anything to do with a satisfaction survey. [s. 85. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee seeks the advice of the Residents' Council in developing and carrying out the satisfaction survey, acting on it's results and that the documented results of the survey are made available to the Residents' Council, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

Inspector #595 observed the medication cart on May 27, 2015 along with S#100. Inspector located a bottle of Novasen 325mg which expired in March 2015. The expiration date was confirmed by S#100, who also stated that the home does not typically use this medication.

Inspector #595 also observed the medication supply room with S#102. Inspector located a bottle of Bronchophan Expectorant which expired in March 2015. The expiration date was confirmed by S#102. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered an annual dental assessment and other preventive dental service, subject to payment being authorized by the resident/SDM if payment is required.

Inspector #542 reviewed the health care record for resident #001 and was unable to locate any information with regards to an annual dental assessment. The inspector spoke with S#100 who indicated that the home does not offer annual dental assessments. Inspector #542 spoke with the Director of Care (DOC) regarding dental assessments. She informed this inspector that the home has tried to obtain someone to complete dental assessments however they have been unsuccessful and that the home currently does not offer annual dental assessments. [s. 34. (1) (c)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that semi-annual meetings are convened to advise residents families and persons of importance to residents of their right to establish a Family Council.

Inspector was informed by the Director of Care that S#107 was the staff member responsible for assisting the Family Council. Inspector spoke with S#107 who stated that the home provided a Family Council information sheet and booklet to family members in March of this year during annual care conferences. The staff member stated that they were planning to send out a memo in June/July this year as another notification to the family members to advise them that they have the right to establish a Family Council. Inspector asked if the home held a second meeting, and the staff member stated that the home was not holding semi-annual meetings.

Inspector spoke with the Director of Care who stated that before the memo, staff would inform family members through word of mouth for the semi-annual notification, and that the home was currently getting ready to send out a memo. The staff member did not mention that the home was holding semi-annual meetings to advise such persons of the right to establish a Family Council. [s. 59. (7) (b)]

Issued on this 24th day of July, 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) :	JENNIFER LAURICELLA (542), MARINA MOFFATT (595)
Inspection No. / No de l'inspection :	2015_281542_0009
Log No. / Registre no:	S-000831-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 3, 2015
Licensee / Titulaire de permis :	BINGHAM MEMORIAL HOSPITAL 507 8th Avenue, PO Box 70, Matheson, ON, P0K-1N0
LTC Home / Foyer de SLD :	ROSEDALE CENTRE 507- 8th Avenue, P.O. Box 70, Matheson, ON, P0K-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Diane Stringer

To BINGHAM MEMORIAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
   i. a physician,
   ii. a registered nurse,
   iii. a registered practical nurse,
   iv. a member of the College of Occupational Therapists of Ontario,
   v. a member of the College of Physiotherapists of Ontario, or
   vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the use of a PASD to assist a resident with a routine activity of daily living is included in a resident's plan of care only if the use of the PASD has been consented to.

The plan shall include a detailed description of what steps the home will take to ensure for all residents who use PASDs, that the use has been consented to by either the resident and if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. The plan shall also include specified time frames for the development and implementation and identify the staff member (s) responsible for the implementation.

The plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5
Email: jennifer.lauricella@ontario.ca

The plan must be submitted by July 17th, 2015 and fully implemented by July 31, 2015

Grounds / Motifs :

1. The licensee has failed to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living is included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Inspector #595 observed resident #013 in their wheelchair with a PASD in place. Inspector reviewed the resident's care plan which identified that the PASD was to be used to keep the resident in correct positioning. Inspector reviewed the resident's health care record and could not find a consent for the PASD.

Inspector spoke with S#100 who stated that the home does not obtain consent for PASDs, only restraints. (595)

2. Inspector #595 reviewed the health care record for resident #014. It was identified in the care plan that the resident used two bed rails as a PASD. Inspector observed the resident sleeping in bed with both bed rails raised.

Inspector spoke with S#101, S#102, and S#103 who all confirmed that the resident used two bed rails while in bed as a PASD. Inspector spoke with S#100 who also confirmed that the bed rails were a PASD for this resident. Inspector was also informed by this staff member that the resident had not signed a consent for the bed rails and that the home only obtains consent for restraints, not PASDs. Inspector further reviewed the health care record and could not find a consent signed for the use of the bed rails for resident #014.

During stage one of the inspection, Inspector #542 observed resident #003 in bed with two bed rails in the raised position. Inspector #542 completed a health care record review for resident #003 which indicated on the most current care plan that the resident uses the bed rails as a PASD. Inspector #542 was unable to locate any documentation to support that consent was received for the use of the bed rails. Inspector #542 interviewed S#105 and S#104 who confirmed that resident #003 uses the bed rails as a PASD. Inspector #595 spoke with S#100 who confirmed that the home does not obtain consents for the use of PASDS. (542)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

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

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that where bed rails are used;
1) all residents are assessed for the use of the bed rails to minimize risk to the residents
2) bed systems are evaluated in accordance with evidence-based practices to minimize risk to the resident, specifically entrapment zones and bed rail height and latch reliability.

The plan shall include a detailed description of the steps that the home will take to ensure resident safety, specified time frames for the development and implementation along with the staff member (s) responsible for the implementation.

The plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5
Email: jennifer.lauricella@ontario.ca

The plan must be submitted by July 17th, 2015 and fully implemented by July 31, 2015.

Grounds / Motifs :

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

Inspector #595 reviewed the health care record for resident #014. It was identified in the care plan that the resident used two bed rails. On May 27, 2015 the inspector observed resident #014 sleeping in bed with both bed rails raised. Inspector was informed by S#103, S#102, and S#101 that the resident used two bed rails.

Inspector #595 spoke with S#100 who confirmed that the bed rails were a PASD for the resident so that they could turn and reposition in bed. Inspector reviewed the resident's health care binder and completed assessments in PCC and could not locate a bed rail assessment for this resident or an evaluation of their bed system. (595)

2. On May 26th, 2015, Inspector #542 observed resident #003 in bed with two bed rails in the raised position. Inspector completed a health care record review and was unable to locate any assessments related the residents and their bed system, an evaluation of the bed system, steps taken to prevent entrapment taking into consideration all potential zones and other issues related to the use of bed rails including the height and latch reliability. Inspector #542 spoke with the Director of Care (DOC) who stated that the home has not completed any assessments on the bed systems yet and that residents are not assessed for the use of the bed rails and the bed rails. The DOC also stated that when a resident is admitted to the home, the bed rails are automatically placed in the raised position. (542)

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 3rd day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Lauricella

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