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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 2, 2018	2018_617148_0022	016502-18	Resident Quality Inspection

Licensee/Titulaire de permis

458422 Ontario Limited
220 Emma Street CORNWALL ON K6J 5V8

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

Sandfield Place
220 Emma Street CORNWALL ON K6J 5V8

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

AMANDA NIXON (148), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 10-12 and July 16-20, 2018

This inspection included one complaint inspection related to multiple care issues of an identified resident (Log #026674-17), one critical incident inspection related to a fall of a resident with injury (Log 002374-18/ Critical Incident Report #2778-000004 -18) and one follow up inspection related to a previously issued Compliance Order (Log 007495-18).

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, RAI Coordinator, Nurse Clerk, Office Manager, Activity and Volunteer Supervisor, Activity Aide, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Cook, family and residents.

The Inspectors reviewed resident health care records, documents related to the medication management system, resident council meeting minutes and policies and procedures as required. In addition, the Inspectors toured resident care areas in the home and observed infection control practices, medication administration, staff to resident interactions and resident to resident interactions

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
1 VPC(s)
1 CO(s)
1 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. 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 failed to ensure that where bed rails were used, residents were assessed and the bed system was evaluated in accordance with evidence-based practices and in accordance with prevailing practices, to minimize risk to the resident and steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Specifically, the licensee did not ensure that the resident assessment is conducted resulting in a documented risk-benefit assessment prior to the use of bed rails.

On April 10, 2018, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Follow up Inspection #2018_617148_0008. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by July 6, 2018.

The licensee was ordered to ensure:
1) Bed systems are evaluated in accordance with evidence-based practices to ensure that, as it relates to rotating assist rails, all intermediate positions are evaluated, zone specific test results are to be documented;
2) Development of an interdisciplinary team who will then conduct and document all resident assessments including the risk-benefit assessment in accordance with prevailing practices. Resident assessments by the interdisciplinary team will be conducted prior to the application of bed rails; and
3) The written plan of care for each resident with bed rails in use, is based on an

assessment of the resident providing clear directions to staff as it relates to the use of bed rails.

The licensee evaluated bed systems in accordance with evidence-based practices, developed an interdisciplinary team who conducted and documented the resident assessment and ensured the written plan of care for each resident with bed rails in use provides clear direction.

The licensee did not ensure that the resident assessment resulted in a documented risk-benefit assessment.

Sandfield Place is a long-term care home with 53 licensed beds. At the time of the inspection it was identified that the home has in use rotating assist rails. As of July 16, 2018, the home had at least 14 bed systems with one or more rotating assist rails in use.

During observations of July 10, 2018, Inspector #148 observed 14 bed systems with rotating assist rails in use, including the bed system of resident #021, resident #025, resident #024 and resident #026 with one or two rotating assist rails in use. RPN #102, who was identified as a member of the interdisciplinary team that conducted resident assessments for bed rail use, indicated that the document title Risk Benefit Analysis V2, was the document used for the resident assessment and risk-benefit assessment.

Resident #021 has diagnoses that may contribute to the resident's risk of bed entrapment. The resident's plan of care indicated that the resident uses an assist rail for transferring and repositioning. The Risk Benefit Analysis V2 (RBA) for resident #021 described several factors that may contribute to the resident's individualized risk for bed entrapment. The RBA indicated that the resident requires extensive assistance by two staff for bed mobility and transfers. Within Section 4 of the RBA, question (k) reads "is the resident at risk for bed entrapment", to which the assessor, identified as the RAI Coordinator, answered the question "no". In an interview with the RAI Coordinator, the RAI Coordinator said that the answer "no" was given as the resident was not at risk to fall out of bed. Question (l) of this section, asks in part if the resident is independent for bed mobility to which the answer was "no". When discussed with the RAI Coordinator, the RAI Coordinator said that resident #021 tries to get out of bed independently but is not safe to do so, however, the resident does participate in transfers using the rail. Section 6 of the assessment indicated the resultant action, whereby the RAI Coordinator documented that the bed rails are to be utilized. The rational to support the decision indicated that the resident uses the side rail in the assist position for transferring and

repositioning.

Resident #025 has diagnoses that may contribute to the resident's risk of bed entrapment. The resident's plan of care indicated that the resident uses an assist rail for transferring and repositioning. The Risk Benefit Analysis V2 (RBA) for resident #025 described several factors that may contribute to the resident's individualized risk for bed entrapment. The RBA indicated that the resident requires extensive assistance by two staff for bed mobility and transfers. Within Section 4 of the RBA, question (k) reads "is the resident at risk for bed entrapment", to which the assessor, identified as the RAI Coordinator, answered the question "no". In an interview with the RAI Coordinator, the RAI Coordinator said that the answer "no" was given as the resident was not at risk to fall out of bed. Question (l) of this section, asks in part if the resident is independent for bed mobility to which the answer was "yes". When discussed with the RAI Coordinator, the RAI Coordinator said that resident #025 is independent for bed mobility once transferred into the bed, so this question was answered "yes". Section 6 of the assessment indicated the resultant action, whereby the RAI Coordinator documented that the bed rails are to be utilized. The rational to support the decision indicated that the resident requested the rail in the assist position for transferring and repositioning

The Inspector spoke with the RAI Coordinator to identify where the risk-benefit assessment was documented, to which the RAI Coordinator identified the Risk Benefit Analysis V2. The Inspector questioned where it was documented that the risk of injury with the use or non-use of rails was compared to the benefits. The RAI Coordinator was not clear as to what this would look like or where it could be found. The Inspector noted that the resultant action for both resident #021 and #025 was for bed rails to be utilized. The Inspector questioned how the team came to this decision, to which the RAI Coordinator said that the residents requested the rails. The Inspector noted that several factors were identified in the resident assessment that may contribute to the resident's risk of bed entrapment. The Inspector questioned how these risks identified affected the risk of injury compared to the resident's benefit of having the rail in use. The RAI Coordinator was not able to answer this question or articulate that a risk-benefit assessment had been completed. The RAI Coordinator indicated that the risk-benefit assessment was not conducted with the resident assessment of either resident #021 or #025.

Resident #024 has a plan of care that indicated that the resident uses an assist rail for emotional comfort and security. The Risk Benefit Analysis V2 (RBA) for resident #024 described several factors that may contribute to the resident's individualized risk for bed

entrapment. The RBA indicated that the resident requires extensive assistance by two staff for bed mobility and transfers. Section 4 of the RBA, question (k) reads "is the resident at risk for bed entrapment", to which the assessor, identified as RPN #102, answered the question "yes". Section 6 of the assessment indicated the resultant action, whereby RPN #102 documented that the bed rails are to be utilized. The rational to support the decision indicated that the resident was falling out of bed with no rails. In an interview with RPN #102 it was reported that resident #024 had fallen from bed with and without rails applied.

Resident #026 has diagnoses that may contribute to the resident's risk of bed entrapment. The resident's plan of care indicated that the resident uses an assist rail for emotional comfort and security. The Risk Benefit Analysis V2 (RBA) for resident #026 described several factors that may contribute to the resident's individualized risk for bed entrapment. The RBA indicated that the resident requires total assistance by two staff for bed mobility and transfers. Section 4 of the RBA, question (k) reads "is the resident at risk for bed entrapment", to which the assessor, identified as RPN #102, answered the question "yes". Section 6 of the assessment indicated the resultant action, whereby RPN #102 documented that the bed rails are to be utilized. The rational to support the decision indicated that the resident's family had requested the use of the rails.

The Inspector spoke with RPN #102, the RPN described that with regards to both resident #024 and #026 that the resident's families requested the application of the rails. The Inspector asked RPN #102 to identify where the risk-benefit assessment was documented; where it was documented that the risk of injury with the use or non-use of rails was compared to the benefits. The RPN was not clear as to what this would look like or where it could be found. The Inspector noted that the resultant action for both resident #024 and #026 was for bed rails to be utilized. The Inspector questioned how the team came to this decision, to which the RPN said that the resident's family had requested the rails to be in use. The Inspector noted that several factors were identified in the resident assessment that may contribute to the resident's risk of bed entrapment. The Inspector questioned how these risks identified affected the risk of injury compared to the resident's benefit of having the rail in use. The RPN was not able to answer this question or articulate that a risk-benefit assessment had been completed. The RPN indicated that the risk-benefit assessment was not conducted with the resident assessment of either resident #024 or #026.

The documents reviewed for resident #021, #024, #025 and #026 did not include a documented risk benefit assessment, as per the FDA 2003 clinical guidance document.

In addition, the team conducting resident assessments did not have a clear understanding of the risk benefit assessment that is to be conducted.

The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope of the issue was a level 3, indicating wide spread, as the non-compliance relates to each resident observe with bed rails in use. The compliance history is a level 4 as non-compliance with this section of O.Regulation 79/10 has been issued as follows:
- Compliance Order issued October 24, 2017 (2017_617148_0027)
- Compliance Order issued April 10, 2018 (2018_617148_0008)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The plan of care for resident #018, indicated that the resident is to have a seat belt and personal alarm applied when in wheelchair. The application of such devices relates to the resident's safety and fall risks.

On the morning of a specified date, Inspector #148 observed resident #018 to be seated in a wheelchair. The resident did not have a seat belt or personal alarm applied. The Inspector approached the RAI Coordinator who repositioned the resident and applied the seat belt. The RAI Coordinator confirmed that the resident is to have the seat belt applied while in the chair.

The Inspector spoke with the two staff members who provided morning care to the resident, PSW #107 and PSW #108. Both staff indicated their awareness that the seat belt and personal alarm were required; neither staff could recall applying the devices after the resident was transferred to the wheelchair and taken to the morning meal. PSW #108 promptly retrieved the alarm and applied it to the resident.

On a specified date, resident #018 was not provided with care as set out in the plan of care as it relates to the application of devices, specifically a seat belt and personal alarm.

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a drug was administered to resident #024 on a specified date in accordance with the directions for use specified by the prescriber.

On a specified date, RPN #113 reported a medication incident whereby resident #024 missed a scheduled dose of medication. RPN #113 reported that the medication tablet was missing in the medication strip dispensed from the home's pharmacy.

Inspector #547 reviewed resident #024's health care records for the specified period. The resident's medication administration record indicated the resident missed a dose of prescribed medication. RPN #113 documented assessment of the resident to have had no ill effect from the missed scheduled dose.

As such, resident #024 was not administered a medication in accordance with the directions for use specified by the prescriber.

Issued on this 2nd day of August, 2018

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148), LISA KLUKE (547)
Inspection No. / No de l'inspection :	2018_617148_0022
Log No. / No de registre :	016502-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 2, 2018
Licensee / Titulaire de permis :	458422 Ontario Limited 220 Emma Street, CORNWALL, ON, K6J-5V8
LTC Home / Foyer de SLD :	Sandfield Place 220 Emma Street, CORNWALL, ON, K6J-5V8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephanie Kinnear

To 458422 Ontario 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: 2018_617148_0008, 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 must be compliant with O. Reg. 79/10, s. 15 (1)
Specifically the licensee must:
a) Ensure that residents #021, #024, #025 and #026 and any other resident, are assessed in accordance with the prevailing practices document Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003). That is, a risk-benefit assessment is documented, following a resident assessment process, and the identified interdisciplinary team members are to approve of the use of bed rails, before the use of bed rails.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, residents were assessed and the bed system was evaluated in accordance with evidence-based practices and in accordance with prevailing practices, to minimize risk to the resident and steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Specifically, the licensee did not ensure that the resident assessment is conducted resulting in a documented risk-benefit assessment prior to the use of

bed rails.

On April 10, 2018, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Follow up Inspection #2018_617148_0008. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by July 6, 2018.

The licensee was ordered to ensure:
1) Bed systems are evaluated in accordance with evidence-based practices to ensure that, as it relates to rotating assist rails, all intermediate positions are evaluated, zone specific test results are to be documented;
2) Development of an interdisciplinary team who will then conduct and document all resident assessments including the risk-benefit assessment in accordance with prevailing practices. Resident assessments by the interdisciplinary team will be conducted prior to the application of bed rails; and
3) The written plan of care for each resident with bed rails in use, is based on an assessment of the resident providing clear directions to staff as it relates to the use of bed rails.

The licensee evaluated bed systems in accordance with evidence-based practices, developed an interdisciplinary team who conducted and documented the resident assessment and ensured the written plan of care for each resident with bed rails in use provides clear direction.

The licensee did not ensure that the resident assessment resulted in a documented risk-benefit assessment.

Sandfield Place is a long-term care home with 53 licensed beds. At the time of the inspection it was identified that the home has in use rotating assist rails. As of July 16, 2018, the home had at least 14 bed systems with one or more rotating assist rails in use.

During observations of July 10, 2018, Inspector #148 observed 14 bed systems with rotating assist rails in use, including the bed system of resident #021, resident #025, resident #024 and resident #026 with one or two rotating assist rails in use. RPN #102, who was identified as a member of the interdisciplinary team that conducted resident assessments for bed rail use, indicated that the document title Risk Benefit Analysis V2, was the document used for the resident

assessment and risk-benefit assessment.

Resident #021 has diagnoses that may contribute to the resident's risk of bed entrapment. The resident's plan of care indicated that the resident uses an assist rail for transferring and repositioning. The Risk Benefit Analysis V2 (RBA) for resident #021 described several factors that may contribute to the resident's individualized risk for bed entrapment. The RBA indicated that the resident requires extensive assistance by two staff for bed mobility and transfers. Within Section 4 of the RBA, question (k) reads "is the resident at risk for bed entrapment", to which the assessor, identified as the RAI Coordinator, answered the question "no". In an interview with the RAI Coordinator, the RAI Coordinator said that the answer "no" was given as the resident was not at risk to fall out of bed. Question (l) of this section, asks in part if the resident is independent for bed mobility to which the answer was "no". When discussed with the RAI Coordinator, the RAI Coordinator said that resident #021 tries to get out of bed independently but is not safe to do so, however, the resident does participate in transfers using the rail. Section 6 of the assessment indicated the resultant action, whereby the RAI Coordinator documented that the bed rails are to be utilized. The rational to support the decision indicated that the resident uses the side rail in the assist position for transferring and repositioning.

Resident #025 has diagnoses that may contribute to the resident's risk of bed entrapment. The resident's plan of care indicated that the resident uses an assist rail for transferring and repositioning. The Risk Benefit Analysis V2 (RBA) for resident #025 described several factors that may contribute to the resident's individualized risk for bed entrapment. The RBA indicated that the resident requires extensive assistance by two staff for bed mobility and transfers. Within Section 4 of the RBA, question (k) reads "is the resident at risk for bed entrapment", to which the assessor, identified as the RAI Coordinator, answered the question "no". In an interview with the RAI Coordinator, the RAI Coordinator said that the answer "no" was given as the resident was not at risk to fall out of bed. Question (l) of this section, asks in part if the resident is independent for bed mobility to which the answer was "yes". When discussed with the RAI Coordinator, the RAI Coordinator said that resident #025 is independent for bed mobility once transferred into the bed, so this question was answered "yes". Section 6 of the assessment indicated the resultant action, whereby the RAI Coordinator documented that the bed rails are to be utilized. The rational to support the decision indicated that the resident requested the rail in the assist position for transferring and repositioning

The Inspector spoke with the RAI Coordinator to identify where the risk-benefit assessment was documented, to which the RAI Coordinator identified the Risk Benefit Analysis V2. The Inspector questioned where it was documented that the risk of injury with the use or non-use of rails was compared to the benefits. The RAI Coordinator was not clear as to what this would look like or where it could be found. The Inspector noted that the resultant action for both resident #021 and #025 was for bed rails to be utilized. The Inspector questioned how the team came to this decision, to which the RAI Coordinator said that the residents requested the rails. The Inspector noted that several factors were identified in the resident assessment that may contribute to the resident's risk of bed entrapment. The Inspector questioned how these risks identified affected the risk of injury compared to the resident's benefit of having the rail in use. The RAI Coordinator was not able to answer this question or articulate that a risk-benefit assessment had been completed. The RAI Coordinator indicated that the risk-benefit assessment was not conducted with the resident assessment of either resident #021 or #025.

Resident #024 has a plan of care that indicated that the resident uses an assist rail for emotional comfort and security. The Risk Benefit Analysis V2 (RBA) for resident #024 described several factors that may contribute to the resident's individualized risk for bed entrapment. The RBA indicated that the resident requires extensive assistance by two staff for bed mobility and transfers. Section 4 of the RBA, question (k) reads "is the resident at risk for bed entrapment", to which the assessor, identified as RPN #102, answered the question "yes". Section 6 of the assessment indicated the resultant action, whereby RPN #102 documented that the bed rails are to be utilized. The rational to support the decision indicated that the resident was falling out of bed with no rails. In an interview with RPN #102 it was reported that resident #024 had fallen from bed with and without rails applied.

Resident #026 has diagnoses that may contribute to the resident's risk of bed entrapment. The resident's plan of care indicated that the resident uses an assist rail for emotional comfort and security. The Risk Benefit Analysis V2 (RBA) for resident #026 described several factors that may contribute to the resident's individualized risk for bed entrapment. The RBA indicated that the resident requires total assistance by two staff for bed mobility and transfers. Section 4 of the RBA, question (k) reads "is the resident at risk for bed entrapment", to which the assessor, identified as RPN #102, answered the

the assessment indicated the resultant action, whereby RPN #102 documented that the bed rails are to be utilized. The rational to support the decision indicated that the resident's family had requested the use of the rails.

The Inspector spoke with RPN #102, the RPN described that with regards to both resident #024 and #026 that the resident's families requested the application of the rails. The Inspector asked RPN #102 to identify where the risk-benefit assessment was documented; where it was documented that the risk of injury with the use or non-use of rails was compared to the benefits. The RPN was not clear as to what this would look like or where it could be found. The Inspector noted that the resultant action for both resident #024 and #026 was for bed rails to be utilized. The Inspector questioned how the team came to this decision, to which the RPN said that the resident's family had requested the rails to be in use. The Inspector noted that several factors were identified in the resident assessment that may contribute to the resident's risk of bed entrapment. The Inspector questioned how these risks identified affected the risk of injury compared to the resident's benefit of having the rail in use. The RPN was not able to answer this question or articulate that a risk-benefit assessment had been completed. The RPN indicated that the risk-benefit assessment was not conducted with the resident assessment of either resident #024 or #026.

The documents reviewed for resident #021, #024, #025 and #026 did not include a documented risk benefit assessment, as per the FDA 2003 clinical guidance document. In addition, the team conducting resident assessments did not have a clear understanding of the risk benefit assessment that is to be conducted.

The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope of the issue was a level 3, indicating wide spread, as the non-compliance relates to each resident observe with bed rails in use. The compliance history is a level 4 as non-compliance with this section of O.Regulation 79/10 has been issued as follows:
- Compliance Order issued October 24, 2017 (2017_617148_0027)
- Compliance Order issued April 10, 2018 (2018_617148_0008)
(148)

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 : Sep 28, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

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