



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Public Copy/Copie du public

Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: May 27, Jun 1, 2011; 2011_097101_0003; Critical Incident

Licensee/Titulaire de permis

NORTH YORK GENERAL HOSPITAL
4001 LESLIE STREET, NORTH YORK, ON, M2K-1E1

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

SENIORS' HEALTH CENTRE
2 BUCHAN COURT, NORTH YORK, ON, M2J-5A3

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

AMANDA WILLIAMS (101)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care.

During the course of the inspection, the inspector(s) took measurements of random resident beds with bed rails in unit 1 including the bed of the resident identified in the critical incident.

The following Inspection Protocols were used in part or in whole during this inspection:

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Table with 2 columns: Definitions (English) and Définitions (French). Rows include WN, VPC, DR, CO, WAO.

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 subsections:

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).

Findings/Faits sayants :

- 1) Resident beds with full and split rails were noted on unit 1. The residents within these beds have not been assessed to ensure their bed system and bed rails do not pose any potential safety or entrapment risks to them.
- 2) Four resident rooms were noted to have beds with bed rails and potential zones of entrapment.
- 3) An identified resident was found entrapped in the side rails of their bed on a specified morning.
 - The resident had been identified to be restless while in bed prior to the incident.
 - The resident was placed in a bed with split rails that were approximately 1 foot apart, creating a potential entrapment hazard to residents that are exit seekers and/or restless.
- 4) An identified resident was found in entrapment zone 5 on a specified date.
 - no assessment or audit has been completed throughout the home to date (3 days after the incident) to determine potential entrapment and safety risks to other residents in the home.

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits sayants :

- 1) Three resident rooms had beds with bed rails where 1 or more zones of entrapment were noted (s. 15 (2)(c)).
- 2) Resident beds in unit 1 were noted to have full and split rails present on them creating potential entrapment and safety hazards to residents who have not been assessed to ensure their beds met their safety needs(s. 15 (2)(c)).
- 3) An identified resident had been identified to be restless while in bed prior to the incident. The resident was placed in a bed with split rails that were approximately 1 foot apart, creating a potential entrapment hazard to residents that are exit seekers and/or restless(s. 15 (2)(c)).
- 4) An identified resident was found entrapped in their side rails on a specified morning (s. 15(2)(c)).



Ministry of Health and
Long-Term Care

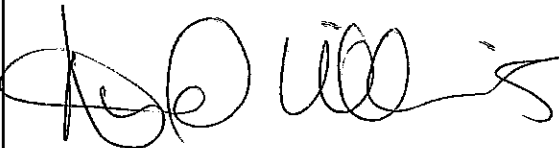
Inspection Report under
the Long-Term Care
Homes Act, 2007

Ministère de la Santé et des
Soins de longue durée

Rapport d'inspection
prévus le Loi de 2007 les
foyers de soins de longue

Issued on this ^{7th}_{th} day of June, 2011

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

A handwritten signature in black ink, appearing to read "A. Williams", is written within a rectangular box.



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

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*

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) :** AMANDA WILLIAMS (101)

**Inspection No. /
No de l'inspection :** 2011_097101_0003

**Type of Inspection /
Genre d'inspection:** Critical Incident

**Date of Inspection /
Date de l'inspection :** May 27, Jun 1, 2011

**Licensee /
Titulaire de permis :** NORTH YORK GENERAL HOSPITAL
4001 LESLIE STREET, NORTH YORK, ON, M2K-1E1

**LTC Home /
Foyer de SLD :** SENIORS' HEALTH CENTRE
2 BUCHAN COURT, NORTH YORK, ON, M2J-5A3

**Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :** ~~SUZANNE MACKENZIE~~ SARA ROONEY AW

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



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

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

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

Order # /

Ordre no : 901

Order Type /

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall assess all residents in the home who use bed rails to ensure all potential safety risks and zones of entrapment are eliminated.

Grounds / Motifs :

1. An identified resident was found in a zone 5 entrapment zone. There has been no assessment or audit completed throughout the home to date to determine potential entrapment risks to other residents. (101)
2. An identified resident was found entrapped in their side rails on a specified morning. The resident had been identified to be restless while in bed prior to the incident. The resident was placed in a bed with split rails that were ~1 foot apart, creating a potential entrapment hazard to residents that are exit seekers and/or restless. (101)
3. Four resident beds with bed rails were noted to have potential zones of entrapment. (101)
4. Four identified resident rooms were noted to have split rails present on them creating potential hazards. The residents' in these beds have not been assessed to ensure their bed system and side rails do not pose any potential safety or entrapment risks to them. (101)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : May 28, 2011



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

REVIEW/APEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

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 Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-760

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

c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Clair Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 27th day of May, 2011

Signature of Inspector /
Signature de l'inspecteur

[Handwritten signature]

Name of Inspector /

Nom de l'inspecteur : AMANDA WILLIAMS

Service Area Office /

Bureau régional de services : Toronto Service Area Office