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 prévue 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 22, 2019	2018_625133_0022 (A2)	018958-18	Critical Incident System

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
2121 Argentia Road Suite 301 MISSISSAUGA ON L5N 2X4

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

Perth Community Care Centre
101 Christie Lake Road, R. R. #4 PERTH ON K7H 3C6

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

Amended by JESSICA LAPENSEE (133) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order #001, related to the use of bed rails, has been closed due to the fact that this licensee is no longer responsible for the management of this long-term care home as of April 1, 2019. The new licensee will be responsible to ensure compliance with the Long-Term Care Homes Act, 2007 as per conditions of their licence.

Issued on this 22nd day of March, 2019 (A2)

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

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

Ministère de la Santé et des Soins de longue durée

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

Amended by JESSICA LAPENSEE (133) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 12, 13, 14, 18, 19, 21, 2018

The following intake was completed in this Critical Incident System Inspection: Log #018958-18, CIS #0962-000012-18; related to an entrapment incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Environmental Coordinator, the Maintenance Coordinator, a RAI Coordinator, the Clinical Care Lead, the Physiotherapist, Registered and non-registered nursing staff, and residents.

During the course of the inspection, the Inspector observed identified residents in their beds, observed residents' bed systems, observed the entrapment zone testing method demonstrated by the Environmental Coordinator, reviewed identified resident's health care records, reviewed documentation related to entrapment zone testing.

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

During the course of the original inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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	Légende 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 :

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

In August, 2012, the Ministry of Health and Long-Term Care issued a memo to all Long-Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

The HC guidance document includes the titles of two additional companion documents. The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used.

Related to the evaluation of residents' bed systems, where bed rails are used, in accordance with evidence-based practices to minimize risk to the residents:

On September 13, 2018, the Inspector and the Environmental Coordinator (EC, #107) met in an office to discuss the evaluation of residents' bed systems. The EC confirmed that in the company of the Maintenance Coordinator (MC, #111), they had performed entrapment zone testing for all of the beds in the home in an

identified month in 2018, following an entrapment incident involving resident #001 on an identified date in 2018. It was confirmed that there were three main styles of bed rails in use in the home; quarter rails at the head of the bed, middle rails (aka assist rails with three positions; down or guard position, up or assist position and back or transfer position) and full rails. When in the up (assist) and down (guard) positions, the middle rails (aka assist rails) are always above the surface of the mattress and these are locking positions. While the rails stop in the back (transfer) position, it is not a locking position. In the back (transfer) position, the rails may be above the surface of the mattress, dependent on the height of the bed deck in the flat position or the elevation of the head section of the bed deck.

Related to the testing of the middle rails (aka assist rails), The EC indicated that they had tested the rails in the down position only. The EC indicated that when the middle rails (aka assist rails) were in the up position, their understanding was that the rails were not considered to be in use. As per the HC guidance document, rails with intermediate stopping or locking positions, such as the middle rails, are to be tested at every intermediate position. Following discussion about the testing requirements outlined in the HC guidance document, the EC indicated that the middle rails (aka assist rails) had not been tested as prescribed.

Related to entrapment zone two, the EC indicated that all of the beds had been tested in the flat position. The EC indicated that they were not aware of a need to consider testing the beds in any position other than flat. As per the HC guidance document, the zone two gap may increase when the bed is articulated, therefore before the test is done, the correct testing position must be found, by raising and lowering the head and foot sections of the bed. As per the HC guidance document, "some full length rails can present an entrapment risk when the bed is articulated, thus testing full length rails in articulated bed positions is particularly important" (page 45). Following discussion about the testing requirements outlined in the HC guidance document, the EC indicated that they had not determined if zone two on the beds was to be tested in a flat position, or a different position, prior to performing the zone two test, as prescribed.

On September 13, 2018, the EC and the Inspector proceeded to resident #002's bedroom, to further discuss entrapment zone testing. As per the EC's bed entrapment zone testing document, resident #002's bed system, had been tested by the EC in an identified month in 2018 and had been noted to pass all of the entrapment zone tests that they had performed. Following initial discussion about

resident #002's bed system, the EC demonstrated the testing process that they had followed for all residents' beds. There was an identified type of bed rail on both sides of resident #002's bed. As a result of the EC's demonstration, it was determined that entrapment zone four failed the test, on both of the rails on resident #002's bed. As a result of the demonstration, and it was established that the EC had not done the test for entrapment zone two or three as prescribed by the HC guidance document, on any of the residents' bed systems. The EC consulted the HC guidance document and performed the test for entrapment zone two and three again. As a result, it was determined that entrapment zone three failed the test, on both of the rails on resident #002's bed. As a result of the entrapment zone three and four failures, resident #002's mattress was changed on September 13, 2018, and the new bed system passed entrapment zone testing.

In summary, it was determined that where bed rails are used, the residents' bed systems had not been evaluated in accordance with evidence based practices, to minimize risk to the residents.

Related to the assessment of residents, where bed rails are used, in accordance with prevailing practices to minimize risks to the residents:

As per the 2003 FDA clinical guidance document: Decisions to use or discontinue use of bed rails is to be made in the context of an individual resident assessment using an interdisciplinary team with input from the resident and family or the resident's legal representative. The factors to be included in the resident assessment are prescribed. Following the assessment, a risk benefit assessment (as prescribed) is to be documented in the resident's health care record. The use of bed rails is to be based on the resident's assessed medical needs, documented clearly and approved by the interdisciplinary team. If clinical and environmental interventions have proven unsuccessful in meeting the residents assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used.

On September 12, 2018, Registered Practical Nurse (RPN) #103 indicated that a bed rail assessment may be done by any of the registered nursing staff. RPN #103 indicated that for new admissions the implementation of bed rail use was based on request and/or what may have been used prior to admission to the home. RPN #103 indicated that when doing a bed rail assessment, it was a matter of completing the form, and not about weighing the "Yes" answers vs. the

"No" answers. The RPN indicated that bed rails are part of the admission orders. RPN #103 indicated that when doing an initial assessment, as opposed to a subsequent quarterly assessment, they would usually discuss the assessment with the Registered Nurse (RN) prior to making a conclusion.

On September 13, 2018, RN #106 indicated that after completing a bed rail assessment for a resident, they would make the decision to put bed rails into use, or to continue the use of bed rails. The RN confirmed that it would not be a team decision, although they may talk to Personal Support Workers (PSWs) or RPNs to gather information when doing an assessment. The RN indicated that even if all of the risk factors on the assessment were selected, bed rails would be put into use if a resident or a resident's POA insisted, as the RN's "hands would be tied". RN #106 qualified that they rarely do the bed rail assessments.

Re: resident #006 – On September 12, 2018, the Inspector observed resident #006 lying in their bed, with an identified type of bed rail, on both sides of the resident's bed, in the up position. On September 13, 2018, the Inspector met resident #006 in their bedroom, and the resident told the Inspector that they probably used the bed rails to grab on to when they sit up in bed. On September 14, 2018, PSW #114 indicated that rails were in use for resident #006 upon the resident's admission to the home. PSW #114 indicated that the resident came in to the home requiring a specified type of transfer, so the bed rails were used automatically.

Resident #006 was admitted to the home on an identified date in 2018. The resident's bed rail assessment, completed 18 days after the resident's admission, by RPN #115, did not include a conclusion. A care plan had not yet been completed for resident #006 at the time of the inspection. Resident #006's Minimum Data Set (MDS) assessment reflected that bed rails were used for a specified purpose, at a specified frequency. On September 14, 2018 RPN #115 confirmed that they had completed the resident's bed rail assessment, on the identified date in 2018, as it had not been done within the first week of the resident's admission. RPN #115 indicated that they had not completed the bottom portion of the assessment, which contains the concluding questions, as it was so darkened that they could not see that there were any words there. RPN #115 indicated that had they known the questions were there, they would have selected that bed rails were not indicated for use for resident #006. The RPN indicated that the resident does not tend to move once the resident is in bed, the resident has the cognitive capacity to use a call bell, the resident can move themselves

independently when in bed, and the resident did not ask for the bed rails to be used. RPN #115 indicated that the bed rail assessment process is not a team decision making process, although they may seek input from the RN that is working when filling in an assessment. RPN #115 indicated there is no documented risk benefit assessment that is developed after completing the bed rail assessment. RPN #115 indicated that there was no process whereby they would weigh the risks of bed rail use vs. the risks of not using bed rails for a resident. RPN #115 indicated that in most cases, they would not be considering alternatives to bed rail use before concluding bed rails were indicated for use. The Inspector and RPN #115 reviewed the factors prescribed for a resident assessment, as per the 2003 FDA clinical guidance document. The RPN #115 indicated that although all of the factors are not captured on the assessment, they would consider factors such as the resident's medical diagnosis, conditions, symptoms, and/or behavioral symptoms when completing an assessment. RPN #115 indicated that with the current process, a resident's sleep habits would not be a consideration when they were completing a resident's bed rail assessment.

Re resident #002 – On September 12, 2018, the Inspector observed that there was an identified type of bed rail, on both sides of the resident's bed, in the up position. PSW #104 indicated that when the resident was put to bed, the bed rails were always up.

Resident #002 was admitted to the home on an identified date in 2018. The resident's initial bed rail assessment was completed 14 days after their admission. There were two subsequent bed rail assessments, completed by RPN #121. The conclusion for each assessment was that side rails were indicated to promote independence. The resident's care plan in place at the time of the inspection reflected bed rail use in the transferring section and bed mobility section.

Re: resident #004 – On September 12, 2018, the Inspector met resident #004 in their bedroom. An identified type of bed rail was in place, on both sides of the resident's bed, in the up position. The resident told the Inspector that they thought they may use the rails to get up out of bed to go to the bathroom at night. PSW #105 indicated to the Inspector later that day that resident #004's rails were always in the up position. On September 13, 2018, PSW #110 indicated that resident #004's rails were always up and provided a reason for that. PSW #110 indicated that they were unsure why rails were in place for resident #004, as the resident could sit up when in bed, independently, and get up out of bed, without the rails.

Resident #004 was admitted to the home on an identified date in 2018. The resident's bed rail assessment, completed seven days following the resident's admission, by RPN #121, concluded that side rails were not indicated at the time. A care plan had not yet been completed for resident #004 at the time of the inspection. Resident #004's Minimum Data Set (MDS) assessment reflected that bed rails were used for a specified purpose, with a specified frequency. On September 18, 2018, RAI Coordinator (RAI C) #116 explained that they had coded for bed rail use for resident #004 as they had met with the resident in their bedroom, six days following the resident's admission, and resident #004 had told the RAI C that they used the bed rails. The RAI C indicated that in addition, given the style of rails on resident #004's bed, the RAI C would always code for bed rails in use.

Re: resident #005 – On September 12, 2018, the Inspector observed that there was an identified type of bed rail, on both sides of the resident's bed, in the up position. PSW #104 indicated that the bed rails were in use for resident #005, to help the resident roll when in their bed, independently and/or with cueing. On September 13, 2018, PSW #110 indicated that they never put resident #005's rails down and had never seen them down.

Resident #005 was admitted to the home on an identified date in 2018. The resident's initial bed rail assessment was completed three days after their admission, by RPN #121. There were two subsequent bed rail assessments, completed by RPN #121. All of the resident's bed rail assessments concluded that side rails were not indicated at the time. The resident's care plan in place at the time of the inspection reflected bed rail use in the bed mobility section. Resident #005's Minimum Data Set (MDS) assessment reflected that bed rails were used with a specified frequency.

On September 21, 2018, the Inspector interviewed RPN #121. RPN #121 confirmed that they had completed bed rail assessments for resident #002, #004 and #005. The RPN indicated that they had completed bed rail assessments for many residents. The RPN indicated that they did not meet with other staff to discuss the results of their assessments, and there was no assessment team. The RPN indicated that when they did an assessment, they were not making decisions about what should be occurring, only verifying what was in place. The RPN indicated that if a new resident had not been assessed and they completed the assessment, they assumed someone else had done an initial assessment and

had not done the paperwork. The RPN indicated that they assumed that when a resident was admitted, the resident had been placed into a bed with rails that were suitable for the resident. The RPN indicated that following a resident assessment, there was no documented risk benefit assessment produced, related to the consideration of alternatives to bed rails, or about the risk of bed rail use vs. the benefits. The RPN indicated that when doing an assessment, they were thinking about risk of falls rather than risk of entrapment. The Inspector and the RPN reviewed the factors specified in the 2003 FDA clinical guidance document for a resident assessment. The RPN indicated that a resident's sleep habits, or ability to toilet self safely, were not a consideration for the bed rail assessment. The RPN indicated that the questions on the bed rail assessment were the only considerations when they were completing the assessment, although a residents communication abilities may be considered when the second section of the assessment was completed, related to reminders to use the call bell. Related to resident #002, RPN #121 indicated that as the initial bed rail assessment concluded that bed rails were indicated to promote independence, they carried that conclusion through the two subsequent assessments that they completed. The RPN indicated that resident #002 "does not really move much at all" and does not need the bed rails for safety at night. The RPN indicated that for resident #002, the bed rails were in place for the resident to hold on to during the provision of care. Related to resident #004, RPN #121 confirmed that they had selected "side rails not indicated at this time", as it was their understanding that the resident did not require bed rails. The RPN indicated that for the type of rails on resident #004's bed, if the rails were kept in a specified position, it was their understanding that the rails would not be considered to be in use. Related to resident #005, RPN #121 confirmed that they had selected "side rails not indicated at this time" as it was their understanding that the resident did not require bed rails in that they were not required for safety when the resident was in bed.

On September 21, 2018, the Inspector met with Clinical Care Lead (CCL) #122. The CCL explained that during a resident's admission process, they try to present alternatives to bed rails. The CCL indicated that towards the end of the admission process, the bed rail consent form is reviewed and discussed. The CCL indicated that if the resident or the resident's family was asking for bed rails to be used, the consent would be signed and bed rails would be used for the resident. The CCL indicated that the bed rail assessment would not be completed prior to the implementation of bed rails for a resident. The CCL indicated that a risk benefit assessment would not be conducted prior to the implementation of bed rail use for

a resident. The CCL indicated that any member of the registered staff could do the bed rail assessment for a resident, and it would generally be done in accordance with the first RAI MDS cycle. The CCL indicated that there was no interdisciplinary team to assess residents for bed rail use and to make decisions about bed rail use for the residents.

In summary, it was established that where bed rails are used, residents had not been assessed in accordance with prevailing practices, to minimize risk to the residents. [s. 15. (1) (a)]

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

As per Critical Incident Report (CIR) #0962-000012-18, submitted by the home to the Ministry of Health and Long-Term Care on an identified date in 2018, resident #001 was found to be entrapped by their bed rail. The resident had been found in described position. The resident's bed had been in a described position at the time of the entrapment. The resident was assessed by Registered Nurse (RN) #106 and subsequently transferred to the hospital. The resident returned to the home on an identified date in 2018, with no change to the resident's health status.

On September 13, 2018, Inspector met with RN #106 to review and discuss the entrapment of resident #001, as reported in CIR #0962-000012-18. RN #106 explained that they had observed resident #001 shortly before the entrapment incident, on the identified date in 2018, and the resident had been positioned in a described way. RN #106 explained that when they saw the resident after the entrapment incident, the resident was positioned in a different, and described, way. RN #106 indicated that a specified type of mattress had been put into use for the resident six days prior to the entrapment incident. RN #106 indicated that resident #001 had an identified type of bed rail in use, on both sides of the resident's bed. RN #106 indicated that with the addition of the specified type of mattress, it was understood that the newly created bed system would not pass entrapment zone testing because of the design of the mattress. RN #106 indicated that they had implemented the use of the specified type of mattress in response to an identified aspect of the resident's health condition. RN #106 indicated that they were aware of the increased entrapment risk with the specified type of mattresses, however, they were not thinking about entrapment as the resident was not known to move when in bed and addressing the identified aspect of the resident's health condition was a priority. RN#106 confirmed that when the

specified type of mattress was put into use for resident #001, steps were not taken to prevent entrapment. RN #106 indicated that prior to resident #001's return to the home from the hospital, on an identified date in 2108, a different type of mattress was put onto resident #001's bed, and the new bed system passed entrapment zone testing.

Related to resident #003 – On September 13, 2018, the Environmental Coordinator (EC, #107) indicated that the specified type of mattress that had been in use for resident #001 at the time of the resident's entrapment was currently in use for resident #003. As per the EC's bed entrapment zone testing document, the EC indicated that resident #003's bed system had failed the entrapment zone 7 test that they had performed in the identified month in 2018. The EC indicated that this had been addressed with the use of an identified accessory in an identified location within the bed system. The EC indicated that entrapment zones 1-4 had not been tested, as it was understood that that the zones could not pass the tests due to the design of the mattress.

At approximately 1644 hours on September 13, 2018, the Inspector observed resident #003 sleeping in their bed. An identified type of bed rail was in use, on both sides of the resident's bed, in a specified position. Personal Support Worker (PSW, #108) and the Inspector confirmed that the resident's mattress was of a specified design. PSW #108 indicated that there had been an identified accessory in an identified location within the bed system in the past, however, they did not know where it had gone. PSW #108 provided two examples of when the resident may hold on to one of the rails, in described ways, during the provision of care. PSW #108 indicated that the resident was not known to move on their own and they did not know why the bed rails were needed for resident #003.

On September 19, 2018, the Inspector met with RN #106 to discuss resident #003 and their bed system. RN #106 indicated that resident #003 "does not really need rails", as the resident was not known to move independently in bed, and their bed was always in the lowest position. RN #106 indicated that it was understood that the entrapment zones along the sides of resident #003's bed system would not pass entrapment zone testing. RN #106 confirmed that there had been no steps taken to prevent entrapment for resident #003. The RN indicated that resident #003 could use a different type of mattress. The RN indicated the resident #003's current mattress had been put into use to address an identified aspect of the resident's health condition, which had now resolved.

The RN indicated that following the conversation with the Inspector, they were going to have a specified type of mattress put into place for resident #003 that could pass entrapment zone testing. Later that day, the Inspector confirmed that the specified type of mattress had been put into use for resident #003, and the new bed system did pass entrapment zone testing.

In conclusion, the severity of the issues identified was determined to be a level 3, in that there was actual harm to resident #001 and actual risk to resident #003 in relation to bed rail use and a specified type of mattress, and the potential for actual harm for all other residents with bed rails in use in relation to bed system evaluations and the assessment of the residents. The scope of the issues identified was widespread, at level 3. The home had a compliance history of 2, in that there was one or more unrelated non-compliance in the last 36 months. Consequently, a compliance order will be served to the licensee. [s. 15. (1) (b)]

Additional Required Actions:

(A2)
The following order(s) have been rescinded: CO# 001

Issued on this 22nd day of March, 2019 (A2)

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

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JESSICA LAPENSEE (133) - (A2)
Inspection No. / No de l'inspection :	2018_625133_0022 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	018958-18 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 22, 2019(A2)
Licensee / Titulaire de permis :	Diversicare Canada Management Services Co., Inc. 2121 Argentia Road, Suite 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	Perth Community Care Centre 101 Christie Lake Road, R. R. #4, PERTH, ON, K7H-3C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Cummins

Ontario

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

To Diversicare Canada Management Services Co., Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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

(A2)
The following Order(s) have been rescinded:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

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).

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 22nd day of March, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JESSICA LAPENSEE (133) - (A2)

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