



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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4ième étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: May 1, 2012, 2012\_049143\_0022, Critical Incident

Licensee/Titulaire de permis

SPECIALTY CARE EAST INC.
400 Applewood Crescent, Suite110, VAUGHAN, ON, L4K-0C3

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

TRILLIUM CENTRE
800 EDGAR STREET, KINGSTON, ON, K7M-8S4

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

PAUL MILLER (143)

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, the Director of Clinical Services, the Maintenance Manager and office manager.

During the course of the inspection, the inspector(s) Reviewed resident health care records, maintenance requisitions, toured the second floor of the Court Building and inspected bed rails.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Table with 2 columns: Legend and Legendé. 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



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Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

**Specifically failed to comply with the following 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 saillants :**

1. A Registered Nurse (RN) completed a maintenance request form. In the description of the maintenance problem the RN documented that resident "bed will not move properly. Head of bed will not lower. Side rail does not lock when up. Please see ASAP".

The resident continued to use this bed. Eight days following the maintenance request the resident was leaning on the side rail. The side rail released and the resident fell to the floor sustaining an injury. The resident was transferred to hospital where sutures were required. The resident returned to the home and was placed in a different bed.

On May 1, 2012 the Maintenance Manager reported to the Inspector, that maintenance staff looked at the bed and assessed the issues related to the head of the bed not lowering. The Maintenance Manager reported maintenance staff did not address issues related to the side rail.

The licensee has failed to ensure O. Regulation 79/10 sec 15 (1) c, other safety issues related to bed rails are addressed including latch reliability.

**Additional Required Actions:**

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

Issued on this 2nd day of May, 2012



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

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

*P. Miller*



**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

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**Name of Inspector (ID #) /  
Nom de l'inspecteur (No) :** PAUL MILLER (143)

**Inspection No. /  
No de l'inspection :** 2012\_049143\_0022

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

**Date of Inspection /  
Date de l'inspection :** May 1, 2012

**Licensee /  
Titulaire de permis :** SPECIALTY CARE EAST INC.  
400 Applewood Crescent, Suite110, VAUGHAN, ON, L4K-0C3

**LTC Home /  
Foyer de SLD :** TRILLIUM CENTRE  
800 EDGAR STREET, KINGSTON, ON, K7M-8S4

**Name of Administrator /  
Nom de l'administratrice  
ou de l'administrateur :** Sue Jackson

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To SPECIALTY CARE EAST INC., 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 :** 001      **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 address all safety issues related to the use of bed rails to ensure the reliability of latches on all bed rails used in the home.

**Grounds / Motifs :**

1. A Registered Nurse (RN) completed a maintenance request form. In the description of the maintenance problem the RN documented that resident "bed will not move properly. Head of bed will not lower. Side rail does not lock when up. Please see ASAP".  
The resident continued to use this bed. Eight days following the maintenance request the resident was leaning on the side rail. The side rail released and the resident fell to the floor sustaining an injury. The resident was transferred to hospital where sutures were required. The resident returned to the home and was placed in a different bed.

On May 1, 2012 the Maintenance Manager reported to the Inspector, that maintenance staff looked at the bed and assessed the issues related to the head of the bed not lowering. The Maintenance Manager reported maintenance staff did not address issues related to the side rail.

The licensee has failed to ensure O. Regulation 79/10 sec 15 (1) c, other safety issues related to bed rails are addressed including latch reliability. (143)

**This order must be complied with by /**  
**Vous devez vous conformer à cet ordre d'ici le :** May 11, 2012



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

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

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

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

**REVIEW/APPEAL INFORMATION**

**TAKE NOTICE:**

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

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

The written request for review must include,

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

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

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care  
55 St. Clair Avenue West  
Suite 800, 8th Floor  
Toronto, ON M4V 2Y2  
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the

Director

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

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care  
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](http://www.hsarb.on.ca).

**Director  
c/o Appeals Clerk  
Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11<sup>th</sup> Floor  
Toronto ON M5S 2B1  
Fax: (416) 327-7603**



Ministry of Health and  
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Ministère de la Santé et  
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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*

**RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL**

**PRENDRE AVIS**

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
55, avenue St. Clair Ouest  
8e étage, bureau 800  
Toronto (Ontario) M4V 2Y2  
Télécopieur : 416-327-7603

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

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

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

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
55, avenue St. Clair Ouest  
8e étage, bureau 800  
Toronto (Ontario) M4V 2Y2  
Télécopieur : 416-327-7603

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

**Issued on this 1st day of May, 2012**

Signature of Inspector /  
Signature de l'inspecteur :

Name of Inspector /  
Nom de l'inspecteur : PAUL MILLER

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