Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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119 King Street West 11th Floor
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 19, 2015	2015_189120_0002	H-001432-14	Follow up

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

BILLINGS COURT MANOR
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 6, 2015

An inspection (2014-189120-0056) was previously conducted on August 27, 2014 at which time non-compliance was identified with respect to the safety of bed systems (entrapment zones) and resident assessments around bed rail use. One Order was issued as a result. For this follow-up visit, the conditions that were laid out in the order were met with the exception of one component related to the mitigation of identified bed safety risks to residents. As a result, a newly revised Order is being issued.

During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care regarding bed safety. The licensee's bed entrapment audit report was reviewed, a tour of resident rooms was conducted and a random selection of resident' health care records were reviewed.

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

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2014_189120_0056	120

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 :

1. The licensee did not ensure that steps were taken to prevent resident entrapment for residents where bed rails were used.

During the inspection on January 6, 2015, 11 unoccupied beds were observed to have at least one bed rail in the elevated position and no entrapment mitigation strategies in place such as bolsters and/or bed rail pads. According to the Environmental Services Supervisor (ESS), the identified beds were tested in October 2014 and had failed zone 2, the area between the mattress and under the bed rail. No interventions had been instituted to mitigate the risks for zone 2 entrapment. Residents returning to these beds (where bed rails were elevated) would therefore have a zone 2 safety risk associated with their bed.

A bed in a room on the 3rd floor was observed to be unoccupied and had a 3/4 bed rail elevated on one side. The bed system was identified to have failed zone 2 and did not have gap fillers and/or rail pads in place. The resident was assessed as requiring a bed rail when in bed. No information on how to reduce the entrapment zone risk was included in the assessment or any other documentation.

A bed in another room on the 3rd floor was observed to be occupied by a resident and their right side 3/4 rail was elevated and in use. The bed system was identified to have failed zone 2 and did not have any gap fillers and/or bed rail pads in place. The resident's assessment identified that they were to have their right rail elevated while the resident was in bed for bed mobility, however no information on how to reduce the entrapment zone risk was included in the assessment or any other documentation.

A bed in a room on the 2nd floor was observed to be equipped with an air mattress and occupied by a resident with both 3/4 rails in the elevated position. The rails were padded, however they did not reduce the gap between the flexible air mattress and the rail when pressure was applied. No bolster was identified to be in place. The resident's assessment identified that they were required to have both rails elevated for positioning but no information regarding how to reduce the entrapment zone risk inherent with the air mattress identified.

Residents were also seen occupying beds in 3 rooms on the 2nd floor with one or more bed rails elevated. These three beds did not pass entrapment zone 2 and did not have any risk mitigating accessories in place.

According to the Director of Care, bolsters were available in the home and were implemented on some of the beds, specifically air mattresses, however other beds did not receive any risk mitigating accessories. The information (Kardex) to inform personal support workers regarding rail use for each individual resident had not been printed and distributed and the visual logo had not yet been applied in each resident room. Personal support workers, although provided information regarding the risks of bed entrapment, continued to leave bed rails in the elevated position, creating a potential risk for resident entrapment. [s. 15(1)(b)]

Additional Required Actions:

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

Issued on this 29th day of January, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2015_189120_0002
Log No. / Registre no:	H-001432-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 19, 2015
Licensee / Titulaire de permis :	MARYBAN HOLDINGS LTD 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	BILLINGS COURT MANOR 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lori Turcotte

To MARYBAN HOLDINGS LTD, 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)

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 mitigate any entrapment zone risk(s) for any resident who currently occupies a bed where one or more entrapment zone risks have been identified.

Grounds / Motifs :

1. The licensee did not ensure that steps were taken to prevent resident entrapment for residents where bed rails were used.

During the inspection on January 6, 2015, 11 unoccupied beds were observed to have at least one bed rail in the elevated position and no entrapment mitigation strategies in place such as bolsters and/or bed rail pads. According to the Environmental Services Supervisor (ESS), the identified beds were tested in October 2014 and had failed zone 2, the area between the mattress and under the bed rail. No interventions had been instituted to mitigate the risks for zone 2 entrapment. Residents returning to these beds (where bed rails were elevated) would therefore have a zone 2 safety risk associated with their bed.

A bed in a room on the 3rd floor was observed to be unoccupied and had a 3/4 bed rail elevated on one side. The bed system was identified to have failed zone 2 and did not have gap fillers and/or rail pads in place. The resident was assessed as requiring a bed rail when in bed. No information on how to reduce

the entrapment zone risk was included in the assessment or any other documentation.

A bed in another room on the 3rd floor was observed to be occupied by a resident and their right side 3/4 rail was elevated and in use. The bed system was identified to have failed zone 2 and did not have any gap fillers and/or bed rail pads in place. The resident's assessment identified that they were to have their right rail elevated while the resident was in bed for bed mobility, however no information on how to reduce the entrapment zone risk was included in the assessment or any other documentation.

A bed in a room on the 2nd floor was observed to be equipped with an air mattress and occupied by a resident with both 3/4 rails in the elevated position. The rails were padded, however they did not reduce the gap between the flexible air mattress and the rail when pressure was applied. No bolster was identified to be in place. The resident's assessment identified that they were required to have both rails elevated for positioning but no information regarding how to reduce the entrapment zone risk inherent with the air mattress identified.

Residents were also seen occupying beds in 3 rooms on the 2nd floor with one or more bed rails elevated. These three beds did not pass entrapment zone 2 and did not have any risk mitigating accessories in place.

According to the Director of Care, bolsters were available in the home and were implemented on some of the beds, specifically air mattresses, however other beds did not receive any risk mitigating accessories. The information (Kardex) to inform personal support workers regarding rail use for each individual resident had not been printed and distributed and the visual logo had not yet been applied in each resident room. Personal support workers, although provided information regarding the risks of bed entrapment, continued to leave bed rails in the elevated position, creating a potential risk for resident entrapment. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 19th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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