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 sions de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 27, 2016	2016_240506_0006	008339-16	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

WELLINGTON PARK CARE CENTRE
802 HAGER AVENUE BURLINGTON ON L7S 1X2

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

LESLEY EDWARDS (506), CAROL POLCZ (156)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 31, April 1, 4, 5, 6, 7, 8, 12 and 13, 2016.

The following inspections were completed concurrently with the RQI:

Complaints

003833-15- related to plan of care, duty to protect and residents bill of rights.

021952-16- related to plan of care.
005798-16- related to responsive behaviours and prevention of abuse and neglect.
005794-16- related to responsive behaviours and prevention of abuse and neglect and residents bill of rights.
009907-16- staffing concerns and dining service.

Critical Incident Reports

003565-14 - related to prevention of abuse and neglect and responsive behaviours.
009657-16- related to prevention of abuse and neglect.

Follow-up Inspections

009242-15 – related to plan of care and collaborating.
009249-15 – related to residents bill of rights.

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care (DOC), Associate Clinical Director of Nursing, Environmental Manager, Food Service Manager (FSM), registered nursing staff, personal support workers (PSW's), Registered Dietitian (RD), dietary staff, recreation staff, social worker, housekeeping staff, Resident Assessment Instrument (RAI) Co-ordinator, families and residents.

During the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures, staffing schedules and resident health records and conducted interviews.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **6 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
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2015_343585_0006	506
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2015_343585_0006	506

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 has failed to ensure that where bed rails were used, that the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #035 was observed to have a quarter rail in the engaged position on the left side of the bed and a quarter rail in the 'up' position on the right hand side of the bed on an identified date in April 2016. Interview with staff member #107 confirmed that the resident uses the bed rail on the right side for positioning and transferring. The bed rail in the 'up' position had not been assessed and the bed system was not evaluated to minimize risk to the resident as confirmed with registered staff #107 and the Associate Clinical Director of Nursing on the same date.
B) The bed of resident #036 was observed to have a quarter rail in the 'up' position on an identified date in April 2016. Registered staff #107 confirmed that the resident used the bed rail in the 'up' position for positioning and transferring and had not been assessed and the bed system was not evaluated to minimize risk to the resident as confirmed with registered staff #107 and the Associate Clinical Director of Nursing on the same date. Registered staff #107 reported that 80% of the beds in the home had quarter rails in the 'up' position that could not be put down. The rails were either 'up' or 'engaged'. It was confirmed that residents with these rails in the 'up' position had not been assessed and their bed systems evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the residents. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for residents sets out the planned care for the residents related to falls prevention.

A. Resident #005's health record indicated that the resident was at a high risk for falls and was in the falls management program which focuses on falls prevention strategies. During an observation it was noted that the resident had a crash mat on the floor in their room. Interview with registered staff #104 confirmed that the resident uses a crash mat while in bed and confirmed that the above fall prevention strategies were not set out in the resident's documented plan of care related to falls prevention.
B. Resident #010's health record indicated that the resident was at a high risk for falls and required safety checks for high risk for falling. Interview with registered staff #103 confirmed that the resident used specific fall prevention interventions identified and confirmed that these fall prevention strategies were not set out in the resident's documented plan of care related to falls prevention. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

The plan of care for resident #002 indicated that the resident had been attending an identified dining room on a trial basis due to behaviours on another dining area, however, this was resolved as the resident was moved to an identified home area on an identified date in February 2016. Interview with the Associate Clinical Director of Nursing and registered staff #104 on an identified date in April 2016 reported that the plan of care was not clear as the resident no longer goes to the identified dining room and remains on their current unit for all meals. [s. 6. (1) (c)]

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 planned care for residents is included in the residents plan of care and the residents plans of care set out clear directions to staff who provide care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

It was observed and confirmed with the Administrator that not all areas accessible to residents were equipped with a resident-staff communication and response system, specifically the dining room on Rose Court and Lotus Way. [s. 17. (1) (e)]

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 home is equipped with a resident-staff communication and response system that is available in all areas accessible by residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #026 was protected from verbal abuse by anyone and free from neglect by the licensee or staff in the home.

i. A review of the home's investigation notes from the incident on an identified date in April 2016, indicated that resident #026 called for assistance as they needed care provided. PSW #106 responded to the call bell and the resident advised the staff member that they needed care provided. The resident stated that the PSW was mean and nasty. Resident #026 stated that the staff member ripped off the sheets and when they ripped off the fitted sheet the resident felt they were going to fall to the ground. The resident stated that they were in tears and scared. The roommate was awakened during this incident.
ii. Interview with resident #024 confirmed what resident #026 reported. Resident #024 stated that they were woken up because it was so loud and the nurse was not very friendly and was yelling at the resident because they were incontinent. Resident #024 also stated that they were incontinent as well but did not call for assistance because they were afraid of the nurse.
iii. Interview with resident #026 and #024 on an identified date in April 2016, were consistent with the home's investigation. A mandatory report was submitted to the Director. Resident #026 and #024 were not protected from verbal abuse by PSW #106. [s. 19. (1)]

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 all residents are protected from verbal abuse, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team who provided the resident's care was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker (SDM).

A. Resident #020 was admitted to the home in February 2015. A review of the resident's progress notes, in the clinical record, identified that the initial, six week care conference was not completed until 91 days following admission. Interview with the Administrator confirmed, that the care conference was not completed within six weeks of admission as required.
B. Resident #009 was admitted to the home in February 2015. A review of the resident's progress notes, in the clinical record, identified that the initial, six week care conference was not completed until 85 days following admission. [s. 27. (1) (a)]

2. The licensee failed to ensure that the resident, the resident's substitute decision–maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conference.

A. During an interview with resident #009's SDM they confirmed that they were not invited to attend the initial, six week care conference at the home. During a clinical review of the resident's clinical record it was confirmed that the initial care conference did not take place until 85 days following admission and it is documented that the family were not in attendance at the conference. Interview with staff member #102 confirmed that there was no record to indicate if the family was invited to participate in the conference. [s. 27. (1) (b)]

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 care conferences are held within six weeks of admission and SDM's are given the opportunity to participate fully in the conference, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1.The licensee failed to ensure that the food production system provided for, at minimum, standardized recipes and production sheets for all menus.

During the kitchen tour on an identified date in April 2016, it was noted that the home had recipes, however, the recipes did not accurately guide staff in food production as quantities listed on the recipes did not reflect what was actually to be prepared. Discussion was held with the FSM regarding food production, census and standardized recipes and it was confirmed that the home did not have food production sheets to guide the production of food items in the home. [s. 72. (2) (c)]

2. The licensee failed to ensure that there was a cleaning schedule for all the equipment related to: the food production system, dining and snack areas.

During the kitchen tour on an identified date in April 2016, it was noted that the kitchen and food production areas were in need of deep cleaning. Old food and beverage splashes were found on the walls and food equipment. The temperature dials for the ovens were found to be covered in food debris. The floors including the corners were stained and in need of a deep cleaning. The stainless table in the kitchen had an oven rack that was covered with dust and cob webs were found near the shelving. The FSM confirmed that the kitchen was in need of cleaning and that the cleaning schedules in place (not found in the kitchen at the time of the inspection) were not complied with. [s. 72. (7) (b)]

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 the food production system provides a minimum standardized recipes and production sheets for all menus and that there is a cleaning schedule for all equipment related to dining and snack areas, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that seat belts were applied according to manufacturer's guidelines.

A. On an identified date in April 2016, resident #023 was noted to be wearing a seat belt that was loose fitting and not applied according to manufacturer's guidelines. Interview with registered staff #103 confirmed that the seat belt was loose fitting and more than five inches from the resident's abdomen. Registered staff #103 also confirmed that the seat belt was a restraint and the resident could not remove the seat belt.
Registered staff #103 confirmed that the staff were aware, based on education that they had received, that seat belts used to restrain a resident should be tightened to the distance of approximately two finger widths. [s. 110. (1) 1.]

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 manufacturer's guidelines are followed when applying seat belts, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The home Abuse and Neglect policy RCS P-10 revised July 2, 2015 indicated that "where a staff member has reason to believe that a resident has suffered harm or is at risk of harm due to abuse or neglect, improper or incompetent treatment or care, or unlawful conduct, they must immediately report their suspicion and the information upon which it is based, to the home, and to the Director appointed under the Long Term Care Homes Act, 2007". Under section C of the policy, mandatory reports, it indicated and set out in the LTCHA, any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, shall immediately report the suspicion and the information upon which it was based to the Director of Long Term Care homes: abuse of a resident by anyone, or neglect of a resident by the licensee or staff member that resulted in harm or a risk of harm to the resident.

According to the progress notes, resident #002 was involved in a inappropriate interaction with co-resident #031 on an identified date in February 2016. The incidents as detailed in the progress notes suggested that there were reasonable grounds to suspect abuse to co-resident #031. Interview with the DOC confirmed that the incident was not reported to the Director as required. [s. 20. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the menu cycle included alternate choices of entrees, vegetables and desserts at lunch and dinner.

During the lunch meal observation on the third floor dining room on an identified date in March 2016, the menu indicated that bananas and ice cream were to be provided for dessert. As confirmed with Dietary staff #100, residents on thickened fluids were not to receive ice cream, and therefore, were provided with pureed bananas. It was also confirmed that the menu did not include an alternate choice for dessert for residents on thickened fluids. On an identified date in March 2016, there were six residents in the dining room requiring thickened fluids who were not provided with an alternate choice for dessert at lunch. The menu cycle did not include an alternate choices of dessert. [s. 71. (1) (c)]

Issued on this 2nd day of May, 2016

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LESLEY EDWARDS (506), CAROL POLCZ (156)
Inspection No. / No de l'inspection :	2016_240506_0006
Log No. / Registre no:	008339-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 27, 2016
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2
LTC Home / Foyer de SLD :	WELLINGTON PARK CARE CENTRE 802 HAGER AVENUE, BURLINGTON, ON, L7S-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kevin Baglole

To RYKKA CARE CENTRES LP, 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 complete the following:
1. Re-assess all bed systems using the Health Canada Guidelines tilted "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006".
2. Implement interventions to reduce or eliminate entrapment zones for those residents who have a therapeutic surface on their bed frame and who use one or more bed rails. Document the intervention in the residents' plan of care.
3. All residents who use a bed rail shall be assessed for bed rail use by employing the guidelines identified in the FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
4. The result of the assessment shall be documented in the residents' plan of care and the information regarding the resident's bed rail use (which side of bed, size of rail, how many rails and why) shall be clearly identified so that health care staff have clear direction.
5. All health care workers shall receive education on the hazards of bed rail use.

Grounds / Motifs :

1. The order is made up on the application of the factors of severity (2), scope (3), and compliance history (4), in keeping with r. 15 (1) (a) of the Regulation, in respect to the potential harm for resident #035 and #036, the scope of this being a widespread issue in the home, and the licensee's history of non-compliance with a (VPC) in February 2015, during the Resident Quality Inspection for r. 15. (1) (a).

The licensee has failed to ensure that where bed rails were used, that the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #035 was observed to have a quarter rail in the engaged position on the left side of the bed and a quarter rail in the 'up' position on the right hand side of the bed on an identified date in April 2016. Interview with staff member #107 confirmed that the resident uses the bed rail on the right side for positioning and transferring. The bed rail in the 'up' position had not been assessed and the bed system was not evaluated to minimize risk to the resident as confirmed with registered staff #107 and the Associate Clinical Director of Nursing on the same date.
B) The bed of resident #036 was observed to have a quarter rail in the 'up' position on an identified date in April 2016. Registered staff #107 confirmed that the resident used the bed rail in the 'up' position for positioning and transferring and had not been assessed and the bed system was not evaluated to minimize risk to the resident as confirmed with registered staff #107 and the Associate Clinical Director of Nursing on the same date.
Registered staff #107 reported that 80% of the beds in the home had quarter rails in the 'up' position that could not be put down. The rails were either 'up' or 'engaged'. It was confirmed that residents with these rails in the 'up' position had not been assessed and their bed systems evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the residents. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 27, 2016

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
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 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 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
Inspection de sions de longue durée
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
Inspection de sions de longue durée
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 27th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lesley Edwards

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