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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 15, 2015	2015_371193_0006	T-1550-14	Follow up

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

CAREFREE LODGE
306 FINCH AVENUE EAST NORTH YORK ON M2N 4S5

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

MONICA NOURI (193)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 7 and 8, 2015.

The inspector observed residents and staff-residents interactions, reviewed health records, audits and applicable policies and procedures.

During the course of the inspection, the inspector(s) spoke with residents, personal support workers (PSW), registered staff, physiotherapist (PT), occupational therapist (OT), Supervisor of Building Services, Director of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
- **3 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	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 :

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

Section 15(1)(b) of the O. Reg. 79/10 was previously issued on June 9, 2014, during inspection # 2014_159178_0005 with a due date for a compliance order of July 31, 2014, and re-issued on December 1, 2014, during the inspection # 2014_157210_0017 with a due date for a compliance order of January 5, 2015.

On December 30, 2014, the licensee conducted a bed system audit for all beds in the home to identify possible entrapment zones. Numerous beds, including the beds of resident #1 and #2, have been identified with entrapment risk in zone 6 and 7, specifically between the end of the bed rail and the side edge of the head or foot board and/or between the head or foot board and the mattress. A bedrails use audit was conducted on March 31, 2015, and identified the beds with bedrails and entrapment zones. Interview with PSWs and registered staff indicated the results of the audit were not shared with them and they were not aware of which beds pose an entrapment risk for residents.
The licensee contacted the bed supplier to order the necessary parts that would solve the entrapment risk identified, however the parts have not been received yet.
Observation of randomly chosen beds identified in the audit as presenting risk for entrapment revealed no interventions have been put in place to prevent resident entrapment.
Record review and staff interview with personal support workers, registered staff and the home's Supervisor of Building Services confirmed that, at the present time, no steps have been taken to mitigate the risk of entrapment for residents who are using these beds. [s. 15. (1) (b)]

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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plans of care set out clear directions to staff and others who provide direct care to residents.

a) Review of the resident #2's plan of care, specifically the current care plan, revealed contradictory information.
The resident requires total assistance of two staff with mechanical lift for all transfers in and out of the bed and wheelchair due to non weight bearing. However, the next sentence indicates two staff to pivot transfer due to improved weight bearing status.
Interview with the resident's primary care giver revealed she transfers the resident alone by pivot and not using a mechanical lift or help of another staff because she believes the resident can bear weight.
An identified registered staff confirmed the directions related to the resident's transfer are not clear. [s. 6. (1) (c)]

b) Review of the resident #1's last completed Minimum Data System assessment indicated the resident is transferred mechanically using a lift.
The current care plan available for PSWs use, indicated extensive assistance of two staff

in all transfers due to resistance and aggression, however, there is no indication of how the transfers should be completed (mechanically or manually).
The most recent physiotherapy assessment indicates the resident's health status had deteriorated after the return from the hospital and the resident needs to be transferred by two staff with a mechanical lift.
An identified registered staff interview confirmed that the resident's plan of care does not set out clear directions to staff and others who provide direct care to the resident in relation to the mode of transfer, as the resident should be transferred by two staff using a mechanical lift.
Interview with an identified PSW revealed she transferred the resident on April 7, 2015, alone by pivot. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan in relation to transfers.

The current plan of care for resident #1 indicates that the resident requires total assistance of two staff for all transfers.
Interview with primary care giver indicates that she transfers the resident alone by pivot because the resident can weight bear. The PSW is aware of the care set out in the resident's plan of care, however, she chooses to transfer her alone. [s. 6. (7)]

4. The licensee has failed to ensure that resident's # 1 plan of care was reviewed and revised after the resident's return from the hospital.

Record review revealed the resident returned from the hospital on an identified date in 2015.
Physiotherapy assessment completed three days after the resident's return, indicates the resident's health condition deteriorated and the resident requires mechanical lift for transfers with two staff assistance at all times. This information was not transferred to the resident's plan of care available to PSWs for reference.
Interview with an identified registered staff confirmed the resident's plan of care had not been revised after the resident's return from the hospital. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's policy "Bedrail Use for Resident Self Mobility" published on 01-11-2014 was complied with.

The policy states under section A. 1. Bedrail Assessment for RN/RPN (registered nurse/registered practical nurse) to assess the resident need for bed rails when there is a change in self performance for mobility status using the bedrail algorithm (Appendix A).

a) Record review and registered staff interview confirmed there was no assessment conducted for resident #1 after the resident's return from the hospital and documentation in the progress notes indicates decline in self performance.
The resident was observed during the inspection in bed with bilateral 1/4 side rails in up position.

b) Resident #2 was identified in the previous order as using a 1/4 side rail for bed mobility, repositioning and transfer, however, the risk for entrapment was not assessed at that time.
Resident's observation on April 7 and 8, 2015, revealed the side rail was removed from the bed.
Record review and registered staff interview confirmed the side rail was removed on April 3, 2015, and no assessment was conducted for the resident prior to the removal of the side rail.
Record review and interview with DOC indicated 11 other residents had side rails removed on April 3, 2015.
Record review and registered staff interview confirmed there were no assessments completed for these residents prior to removal of side rails as required by the home's policy.

The policy also indicates on section A.2. for the OT (occupational therapist) to assess all residents deemed to require a bed rail when there is a change in self performance for mobility status.
Record review and interview with OT confirmed no assessments have been conducted for resident #1, 2 and other 11 residents who had their side rails removed on April 3, 2015. [s. 8. (1) (a)]

Issued on this 15th day of April, 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) :	MONICA NOURI (193)
Inspection No. / No de l'inspection :	2015_371193_0006
Log No. / Registre no:	T-1550-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 15, 2015
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	CAREFREE LODGE 306 FINCH AVENUE EAST, NORTH YORK, ON, M2N-4S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Alice Marak

To TORONTO LONG-TERM CARE HOMES AND SERVICES, 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)

Linked to Existing Order / Lien vers ordre existant: 2014_157210_0017, CO #001;

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 must ensure that:
1. Shares the results of the bed system audit with all direct care staff to ensure their awareness of the specific beds that pose entrapment risk by April 20, 2015
2. Develops and implement strategies to monitor and mitigate the risk for residents identified in the bed audit at risk for entrapment by April 20, 2015
3. Provide staff education on entrapment zones where bedrails are used by May 4, 2015
4. Explore other avenues/sources for the supply of parts to expedite the resolution of this issue
5. Submit a plan to Monica.Nouri @ontario.ca by April 20, 2015, to identify the installation schedule and who is responsible for the installation of the parts when received
6. Install the bed parts immediately upon delivery to the home
7. Complete another bed audit once the parts are installed to ensure the risk of entrapment has been eliminated

Grounds / Motifs :

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

Section 15(1)(b) of the O. Reg. 79/10 was previously issued on June 9, 2014, during inspection # 2014_159178_0005 with a due date for a compliance order of July 31, 2014, and re-issued on December 1, 2014, during the inspection # 2014_157210_0017 with a due date for a compliance order of January 5, 2015.

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Observation of randomly chosen beds identified in the audit as presenting risk for entrapment revealed no interventions have been put in place to prevent resident entrapment.
Record review and staff interview with personal support workers, registered staff and the home's Supervisor of Building Services confirmed that, at the present time, no steps have been taken to mitigate the risk of entrapment for residents who are using these beds. (193)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 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 15th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MONICA NOURI

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