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 soins de longue durée

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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
Aug 31, 2016	2016_336620_0019	016013-16	Critical Incident System

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST
400 Olive St. NORTH BAY ON P1B 6J4

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

CASSELLHOLME
400 OLIVE STREET NORTH BAY ON P1B 6J4

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

ALAIN PLANTE (620)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 30, 31, June 01, 02, 03, 2016

This Critical Incident (CI) inspection was related to an incident of Improper/Incompetent treatment of a resident.

The inspector reviewed residents' health records, various policies, procedures, programs, training records, and a number of the home's investigation documents. The Inspector also observed the delivery of resident care, and bed system use and functionality.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Maintenance Manager, Registered Nurses (RN), the Manager of Laundry Services (MLS), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, and residents' Substitute Decision Makers (SDMs).

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

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

Inspector #620 reviewed a Critical Incident report related to improper/incompetent treatment. The incident report described that resident #001's co-resident activated their call bell to alert staff that resident #001 had fallen. RPN #104 and PSW #105 responded to the call bell and found that resident #001 had fallen from their bed onto the floor.

The report also indicated that both of the resident's bed rails were engaged in a certain position. A certain device that the resident was required to utilize was turned off and the bed was askew to its usual position. The bed was resting on casters and off of the immobilized legs and the casters were unlocked leaving the bed free to move.

The report indicated that resident #001 had experienced numerous falls. The report also indicated that as a result of the fall, resident #001 was under increased observation. It also stated that resident #001 experienced negative health effects for which the Physician ordered a certain treatment.

1. A review of resident #001's plan of care indicated a number of specific interventions. The interventions indicated that the resident's be rails were to be engaged in a certain position when the resident was in bed, to protect the resident from falling out of bed. The plan of care also indicated that a certain device was to be installed on the bed.

Inspector #620 interviewed PSW #108 who confirmed that resident #001 had not had a certain device installed on their bed as was indicated in the plan of care. This was further confirmed by the ADOC who stated that the resident did not have the device installed.

2. The plan of care also advised staff to ensure that a warning device was in place on bed and functioning.

A review of the home's investigation revealed that resident #001's warning device was functional; however, at the time of the fall the device was noted to be deactivated.

Inspector #620 interviewed the DOC. The DOC confirmed that the warning device was functional but at the time of the incident the device had been found to be deactivated. The DOC stated that they were unable to determine who deactivated the device.

3. The plan of care advised staff to, increase resident observation.

Inspector #620 reviewed the home's investigation notes which revealed that PSW #108 had last seen resident #001 at a certain time. The investigation notes indicated that

resident #001 had not received increased observation as indicated in the plan of care.

Inspector #620 interviewed the ADOC. The ADOC confirmed that the resident had not received the increased observation as was required in the plan of care. The ADOC confirmed that resident #001 had gone unchecked for longer than they should have. [s. 6. (7)]

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 O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Inspector #620 reviewed a Critical Incident report related to improper/incompetent treatment. The incident report described that resident #001's co-resident activated their call bell to alert staff that resident #001 had fallen. RPN #104 and PSW #105 responded to the call bell and found resident #001 on the floor.

The report also indicated that both of the resident's rails were engaged in a certain position. The bed (solo brand) was resting on casters and off of the immobilizer legs; the casters were unlocked leaving the bed free to move.

The report indicated that resident #001 had experienced numerous falls. The report also indicated that as a result of the fall, resident #001 was under increased observation. It also indicated that resident #001 experienced negative health effects for which the Physician ordered a certain treatment.

Inspector #620 conducted a review of all of the home's 240 beds. The home had 69 beds that were Echo brand, and 70 that were Solo Brand that worked in the same manner for initiating mobility of the bed unit. If the bed unit needed to be mobilized, the operator was required to lower the bed to its lowest position with the use of the bed pendent and hold the down button. This action would cause the bed to disengage from its immobilizer legs and the bed would come to rest on its casters allowing for bed mobility.

During the review of the beds on one of the units Inspector #620 kneeled down to view the configuration of the caster assembly for bed-A. In doing so, the bed rolled out of position. On closer inspection it was observed that the bed was resting upon its casters and was not immobilized.

The 69 Echo brand beds in the home did not contain locking casters; therefore, if staff inadvertently held the down button too long, the bed would come to rest upon its casters. The manufacturer's instructions documented the following warning, "never leave the bed unattended while wheels are in contact with the floor. For safety reasons, ensure that the immobilizer feet are engaged before leaving bed unattended. Failure to follow the foregoing warnings may result in property damage or resident injury."

The 70 Solo brand beds had the availability of locking casters; however, during the review it was discovered that none of the beds had the caster locks engaged. The manufacturer's instructions documented the following warning, "never leave the bed unattended while wheels are in contact with the floor. For safety reasons, ensure that the immobilizer feet are engaged before leaving bed unattended. Failure to follow the foregoing warnings may result in property damage or resident injury."

Inspector #620 interviewed PSW #108 who confirmed that they had not checked to see that the bed was immobilized before they left resident #001 unattended.

A review of the home's investigation documents revealed a directive to Clinical Services and Housekeeping Staff drafted by the DOC. The document was deemed a high risk safety protocol. The Directive stated, "Due to a recent resident fall incident this memo is to remind staff of the following safety protocols: Always ensure that resident beds are secure and will not move."

Inspector #620 interviewed the DOC who confirmed that resident #001's bed had not been immobilized and that it was askew when the resident was discovered post fall. The DOC stated that the staff should have ensured that the bed was immobilized and that this

had not occurred. [s. 23.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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, 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.

Inspector #620 reviewed a Critical Incident report related to improper/incompetent treatment. The incident report described that resident #001's co-resident activated their call bell to alert staff that resident #001 had fallen. RPN #104 and PSW #105 responded to the call bell and found that resident #001 had fallen from their bed onto the floor.

While trying to locate resident #001's bed, Inspector #620 observed that the bed that had been re-located to another room and was now being utilized by resident #002. Resident #002 was in the bed with a specific bed rail orientation. A document above the resident's bed indicated that resident #002 was intended to have a different rail orientation than what had been observed by the Inspector.

A review of the home's Policy, "Bed Rail Assessment: Policy B16.0" on bed rail assessment advised staff that a bed rail assessment was to be completed by an RN when a resident's mattress was changed, whenever registered staff or the POA were considering the use of bed rails, and if the resident's bed was changed.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012 was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document referenced the 'Clinical Guidance for the Assessment and implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for assessing the use of bed rails.

Inspector #620 conducted a review of resident #002's plan of care. The plan of care indicated that resident #002 was to have a specific bed rail orientation for safety and comfort.

Inspector #620 conducted a review of resident #002's clinical record and discovered the most recent bed/rail assessment. The assessment indicated that the resident was to continue to utilize a specific bed rail orientation; no change to the resident's bed rail orientation was required.

Inspector #620 reviewed an email that was sent to Manager of Laundry Service (MLS) by RN #110. The email dated May 25, 2016 was a request from RN #110 to the MLS to replace resident #002's bed with resident #001's bed. RN #110 was requesting an alternate bed rail orientation for resident #002 for a certain reason. The email indicated that the bed change had been completed.

A review of resident #002's plan of care did not identify that the resident had been assessed and their bed system evaluated before the bed was replaced. There was also no indication that the SDM had been made aware of the bed and bed rail change.

Inspector #620 interviewed the ADOC and the DOC. Both verified that they were unaware of the memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012. Both confirmed that the home was not using the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail

Latching Reliability, and Other Hazards' as a best practice document.

Inspector #620 interviewed the DOC. The DOC confirmed that it was the home's policy to conduct a bed/rail system and resident assessment before a change to their bed system or bed rail configuration. The DOC verified that no bed/rail assessment had occurred for resident #002 before their bed system was changed. [s. 15. (1) (a)]

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 ensuring that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #4: 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 has failed to ensure that the home was equipped with a resident-staff communication and response system that was on at all times.

Inspector #620 reviewed a Critical Incident report related to improper/incompetent treatment. The incident report described that resident #001's co-resident activated their call bell to alert staff that resident #001 had fallen. RPN #104 and PSW #105 responded to the call bell and found that resident #001 had fallen from their bed onto the floor.

The resident's device was turned off and the bed was askew to its usual position. The bed was resting on casters and off of the immobilize legs and the casters were unlocked leaving the bed free to move.

A review of resident #001's plan of care advised staff to ensure the device was in place and functioning.

A review of the home's investigation revealed that resident #001's device was functional; however, at the time of the fall the device had been switched off.

Inspector #620 observed the functionality of the device and discovered that if the device was in the off position, it would have rendered the call system inoperable.

Inspector #620 interviewed the DOC. The DOC confirmed that the device was functional but at the time of the incident the device had been switched into the "off position" so that it was non-functional. The DOC stated that they were unable to determine who turned the device off. The DOC also verified that the inactivation of the device rendered the call system inoperable. [s. 17. (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 ensuring that the home is equipped with a resident-staff communication and response system that is on at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) the restraining of the resident was included in the resident's plan of care.

While trying to locate resident #001's bed Inspector #620 observed resident #002 was in the bed with a certain bed rail orientation. A document above the resident's bed indicated that resident #002 was intended have a different bed rail orientation than what was observed.

Inspector #620 conducted a review of resident #002's plan of care, which indicated that resident #002 was to have a certain bed rail orientation.

Inspector #620 conducted a review of resident #002's clinical record and discovered the most recent bed/rail assessment. The assessment indicated that the resident was to continue to utilize a specific bed rail orientation; no change to the resident's bed rail orientation was required.

Inspector #620 reviewed an email that was sent to Manager of Laundry Service (MLS) by RN #110. The email dated May 25, 2016 was a request from RN #110 to the MLS to replace resident #002's bed with resident #001's bed. RN #110 was requesting an alternate bed rail orientation for resident #002 for a certain reason. The email indicated that the bed change had been completed.

A review of resident #002's plan of care did not identify that the resident had been assessed and their bed system evaluated before the bed was replaced.

Inspector #620 interviewed the DOC. The DOC verified that resident #002's plan of care had not been updated to include a different bed rail orientation when their bed was replaced. The DOC further stated that it was the home's expectation that where restraints were utilized, the restraints were to be reflected in the plan of care and that this had not occurred for resident #002. [s. 31. (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 ensuring that when a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that falls prevention and management training was provided to all staff who provided direct care to residents.

Inspector #620 reviewed a Critical Incident report related to improper/incompetent treatment. The incident report described that resident #001's co-resident activated their call bell to alert staff that resident #001 had fallen. RPN #104 and PSW #105 responded to the call bell and found that resident #001 had fallen from their bed onto the floor.

The report also indicated that both of the resident's bed rails were engaged in a certain position. A certain device that the resident was required to utilize was turned off and the bed was askew to its usual position. The bed was resting on casters and off of the immobilized legs and the casters were unlocked leaving the bed free to move.
Inspector #620 conducted a review of the home's falls prevention management training records for all 183 direct care staff. The records indicated that four of the 183 direct care staff members who had been working in the home had not completed their annual mandatory falls prevention re-training.

Inspector #620 interviewed the ADOC. The ADOC stated that it was the home's expectation that all direct care staff were to complete annual mandatory falls prevention education. The ADOC confirmed that four direct care staff members had not completed their mandatory falls prevention education. [s. 221. (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 ensuring that falls prevention and management training is provided to all staff who provide direct care to residents, to be implemented voluntarily.

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

Issued on this 1st day of September, 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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALAIN PLANTE (620)
Inspection No. / No de l'inspection :	2016_336620_0019
Log No. / Registre no:	016013-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 31, 2016
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST 400 Olive St., NORTH BAY, ON, P1B-6J4
LTC Home / Foyer de SLD :	CASSELLHOLME 400 OLIVE STREET, NORTH BAY, ON, P1B-6J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jamie Lowery

To BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST, 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 :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall:

a) ensure that the care set out in the plan of care is provided to the resident as specified in the plan; specifically,

1) ensure that where bed alarms are indicated in plan of care, that the bed alarms are activated and monitored for functionality as indicated in the plan, and

2) ensure that where increased monitoring of residents is indicated in the plan of care, that staff conduct the monitoring as specified in the plan.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

Inspector #620 reviewed a Critical Incident report related to improper/incompetent treatment. The incident report described that resident #001's co-resident activated their call bell to alert staff that resident #001 had fallen. RPN #104 and PSW #105 responded to the call bell and found that resident #001 had fallen from their bed onto the floor.

The report also indicated that both of the resident's bed rails were engaged in a certain position. A certain device that the resident was required to utilize was turned off and the bed was askew to its usual position. The bed was resting on casters and off of the immobilized legs and the casters were unlocked leaving the bed free to move.

The report indicated that resident #001 had experienced numerous falls. The report also indicated that as a result of the fall, resident #001 was under increased observation. It also stated that resident #001 experienced negative health effects for which the Physician ordered a certain treatment.

1. A review of resident #001's plan of care indicated a number of specific interventions. The interventions indicated that the resident's be rails were to be engaged in a certain position when the resident was in bed, to protect the resident from falling out of bed. The plan of care also indicated that a certain device was to be installed on the bed.

Inspector #620 interviewed PSW #108 who confirmed that resident #001 had not had a certain device installed on their bed as was indicated in the plan of care. This was further confirmed by the ADOC who stated that the resident did not have the device installed.

2. The plan of care also advised staff to ensure that a warning device was in place on bed and functioning.

A review of the home's investigation revealed that resident #001's warning device was functional; however, at the time of the fall the device was noted to be deactivated.

Inspector #620 interviewed the DOC. The DOC confirmed that the warning device was functional but at the time of the incident the device had been found to be deactivated. The DOC stated that they were unable to determine who deactivated the device.

3. The plan of care advised staff to, increase resident observation.

Inspector #620 reviewed the home's investigation notes which revealed that PSW #108 had last seen resident #001 at a certain time. The investigation notes indicated that resident #001 had not received increased observation as indicated in the plan of care.

Inspector #620 interviewed the ADOC. The ADOC confirmed that the resident had not received the increased observation as was required in the plan of care. The ADOC confirmed that resident #001 had gone unchecked for longer than they should have.

Non-compliance was previously identified under inspections #2015_395613_0006, #2013_306510_0003 16, and #2013_306510_0003 with three voluntary plans of correction (VPC) being served to the home.

The decision to issue this compliance order was based on the scope which was identified as isolated, the severity which indicated actual harm or risk of actual harm, and the compliance history which despite previous non-compliance issued including three VPCs, non-compliance continued with this section of the legislation. [s. 6. (7)] (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 16, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee shall:

a) conduct and document an audit of the home's bed systems to identify:

1. which beds have the potential to become mobilized when lowered,

2. which beds have locking casters, and

3. which beds do not have locking casters,

b) develop and implement a bed monitoring system to ensure that the home's bed systems are being utilized in accordance with manufacturers instruction and best practice guidelines, including the following:

1. the development of documentation to identify the immobilization of beds when the beds are relocated.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Inspector #620 reviewed a Critical Incident report related to improper/incompetent treatment. The incident report described that resident #001's co-resident activated their call bell to alert staff that resident #001 had fallen. RPN #104 and PSW #105 responded to the call bell and found resident #001 on the floor.

The report also indicated that both of the resident's rails were engaged in a certain position. The bed (solo brand) was resting on casters and off of the immobilizer legs; the casters were unlocked leaving the bed free to move.

The report indicated that resident #001 had experienced numerous falls. The report also indicated that as a result of the fall, resident #001 was under increased observation. It also indicated that resident #001 experienced negative health effects for which the Physician ordered a certain treatment.

Inspector #620 conducted a review of all of the home's 240 beds. The home had 69 beds that were Echo brand, and 70 that were Solo Brand that worked in the same manner for initiating mobility of the bed unit. If the bed unit needed to be mobilized, the operator was required to lower the bed to its lowest position with the use of the bed pendent and hold the down button. This action would cause the bed to disengage from its immobilizer legs and the bed would come to rest on its casters allowing for bed mobility.

During the review of the beds on one of the units Inspector #620 kneeled down to view the configuration of the caster assembly for bed-A. In doing so, the bed rolled out of position. On closer inspection it was observed that the bed was resting upon its casters and was not immobilized.

The 69 Echo brand beds in the home did not contain locking casters; therefore, if staff inadvertently held the down button too long, the bed would come to rest upon its casters. The manufacturer's instructions documented the following warning, "never leave the bed unattended while wheels are in contact with the floor. For safety reasons, ensure that the immobilizer feet are engaged before leaving bed unattended. Failure to follow the foregoing warnings may result in property damage or resident injury."

The 70 Solo brand beds had the availability of locking casters; however, during the review it was discovered that none of the beds had the caster locks engaged. The manufacturer's instructions documented the following warning, "never leave the bed unattended while wheels are in contact with the floor. For safety reasons, ensure that the immobilizer feet are engaged before leaving bed unattended. Failure to follow the foregoing warnings may result in property damage or resident injury."

Inspector #620 interviewed PSW #108 who confirmed that they had not checked to see that the bed was immobilized before they left resident #001 unattended.

A review of the home's investigation documents revealed a directive to Clinical Services and Housekeeping Staff drafted by the DOC. The document was deemed a high risk safety protocol. The Directive stated, "Due to a recent resident fall incident this memo is to remind staff of the following safety protocols: Always ensure that resident beds are secure and will not move."

Inspector #620 interviewed the DOC who confirmed that resident #001's bed had not been immobilized and that it was askew when the resident was discovered post fall. The DOC stated that the staff should have ensured that the bed was immobilized and that this had not occurred.

The decision to issue this compliance order was based on the scope which was identified as widespread, the severity which indicated actual harm or risk of actual harm, and the compliance history, which identified previously unrelated non-compliance. [s. 23.] (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 16, 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 soins 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 soins 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 31st day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alain Plante

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