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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 11, 2014	2014_178102_0005	000136-13	Follow up

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PORT PERRY)
15941 Simcoe Street, Port Perry, ON, L9L-1N5

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

WENDY BERRY (102)

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): Januray 28 and 29, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Environmental Services Manager, several nursing staff and several residents.

During the course of the inspection, the inspector(s) reviewed documentation related to the evaluation of residents' bed systems; toured the 2nd and 3rd floors; measured a number of bed rails; checked a number of beds.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
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. O. Reg. 79/10, s.15(1)(a) identifies that where bed rails are used, the resident is to be assessed and his or her bed system is to be evaluated in accordance with prevailing practices, to minimize risk to the resident.

Evidence based prevailing practices are identified in Health Canada's guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", effective date 2008/03/17.

During an inspection in the home on January 23 and 24, 2013 bed rails with a potential zone of entrapment within the inner perimeter of the rails were identified to be in use on a number of residents' beds. Covers were in use on many of the identified bed rails; however, the covers did not fully cover potential entrapment zone openings of greater than 120mm (4 3/4 inches) within the bed rails on more than 20 beds. Residents were observed laying in a number of the identified beds with rails in the "up" position. Following the on site inspection, the Administrator identified that a bed system evaluation by an external vendor had been conducted on February 05, 2013. A copy of the report was faxed to the inspector on February 06, 2013. The report identified more than 40 beds with entrapment zone failures. Compliance Order (CO) # 001 was issued for inspection # 2013 178102 0007. A compliance plan in response to the inspection was submitted which identified various immediate, short term and long term actions to comply with the CO. The date for compliance was set at May 08, 2013.

A follow up inspection was conducted on January 28 and 29, 2014. Full length chrome type bed rails with a potential zone of entrapment within the inner perimeter of the rails

were observed to be provided on 20 residents' beds. Covers were in use on many of the identified bed rails; however, the covers did not fully cover potential entrapment zone openings of greater than 120mm (4 3/4 inches) within the rail on 39 of the 40 bed rails. Residents were observed laying in a number of the identified beds with rails in the "up" position. Some of the beds were not occupied when observed; however, one of the two provided rails was in the "up" position.

The Administrator and the Director of Resident Care identified that on July 24, 2013 another bed system assessment was conducted in the home by the same external vendor as in February 2013, with 2 of the LTC home's staff in attendance. Copies of the assessment reports were provided to the inspector during the inspection on January 28 and 29, 2014. Entrapment zone failures were identified on many beds. Management staff of the home confirmed that some adjustments were subsequently made to the beds. A follow up evaluation of the bed systems was not conducted.

At the time of inspection on January 28 and 29, 2014 all necessary steps had not been taken to minimize risk to residents taking into consideration all potential zones of entrapment, placing residents at risk of harm from entanglement in or around the bed rails. [s. 15. (1) (b)]

Additional Required Actions:

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

Issued on this 11th day of February, 2014

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

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) :	WENDY BERRY (102)
Inspection No. / No de l'inspection :	2014_178102_0005
Log No. / Registre no:	000136-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 11, 2014
Licensee / Titulaire de permis :	COMMUNITY LIFECARE INC 1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6
LTC Home / Foyer de SLD :	COMMUNITY NURSING HOME (PORT PERRY) 15941 Simcoe Street, Port Perry, ON, L9L-1N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ROSEMARY MIFSUD

To COMMUNITY LIFECARE INC, 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: 2013_178102_0007, 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 will ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. That will include:
-immediate measures are taken to mitigate risks to residents where beds that are equipped with bed rails that have been evaluated and identified to have potential zones of entrapment and any other safety issues related to the use of bed rails according to Health Canada's guidance document titled " Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" are addressed, and
-a follow up assessment of the beds with bed rails is to be conducted by February 28th, 2014 to ensure that identified entrapment zones and any other safety issues have been resolved.

Grounds / Motifs :

1. O. Reg. 79/10, s.15(1)(a) identifies that where bed rails are used, the resident is to be assessed and his or her bed system is to be evaluated in accordance with prevailing practices, to minimize risk to the resident.

Evidence based prevailing practices are identified in Health Canada's guidance

document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", effective date 2008/03/17.

During an inspection in the home on January 23 and 24, 2013 bed rails with a potential zone of entrapment within the inner perimeter of the rails were identified to be in use on a number of residents' beds. Covers were in use on many of the identified bed rails; however, the covers did not fully cover potential entrapment zone openings of greater than 120mm (4 3/4 inches) within the bed rails on more than 20 beds. Residents were observed laying in a number of the identified beds with rails in the "up" position. Following the on site inspection, the Administrator identified that a bed system evaluation by an external vendor had been conducted on February 05, 2013. A copy of the report was faxed to the inspector on February 06, 2013. The report identified more than 40 beds with entrapment zone failures. Compliance Order (CO) # 001 was issued for inspection # 2013 178102 0007. A compliance plan in response to the inspection was submitted which identified various immediate, short term and long term actions to comply with the CO. The date for compliance was set at May 08, 2013.

A follow up inspection was conducted on January 28 and 29, 2014. Full length chrome type bed rails with a potential zone of entrapment within the inner perimeter of the rails were observed to be provided on 20 residents' beds. Covers were in use on many of the identified bed rails; however, the covers did not fully cover potential entrapment zone openings of greater than 120mm (4 3/4 inches) within the rail on 39 of the 40 bed rails. Residents were observed laying in a number of the identified beds with rails in the "up" position. Some of the beds were not occupied when observed; however, one of the two provided rails was in the "up" position.

The Administrator and the Director of Resident Care identified that on July 24, 2013 another bed system assessment was conducted in the home by the same external vendor as in February 2013, with 2 of the LTC home's staff in attendance. Copies of the assessment reports were provided to the inspector during the inspection on January 28 and 29, 2014. Entrapment zone failures were identified on many beds. Management staff of the home confirmed that some adjustments were subsequently made to the beds. A follow up evaluation of the bed systems was not conducted.

At the time of inspection on January 28 and 29, 2014 all necessary steps had

not been taken to minimize risk to residents taking into consideration all potential zones of entrapment, placing residents at risk of harm from entanglement in or around the bed rails.

(102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

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 11th day of February, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : WENDY BERRY

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