Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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) :	MICHELLE WARRENER (107), DEBORA SAVILLE (192), ELISA WILSON (171), LISA VINK (168)
Inspection No. / No de l'inspection :	2011_066107_0003
Type of Inspection / Genre d'inspection:	Annual
Date of Inspection / Date de l'inspection :	Jun 13, 14, 15, 16, 17, 20, 21, 22, 24, 27, 28, 29, 30, Jul 4, 5, 6, 2011
Licensee / Titulaire de permis :	DELHI NURSING HOME LTD 750 GIBRALTAR STREET, DELHI, ON, N4B-3B3
LTC Home / Foyer de SLD :	DELHI LONG TERM CARE CENTRE 750 GIBRALTAR STREET, DELHI, ON, N4B-3B3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~JIM MILLER~~ DEBORAH BECKMAN

To DELHI NURSING HOME LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

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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

Order # / Ordre no : 001

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

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 prepare, submit and implement a plan regarding the steps being taken to prevent resident entrapment, including any mattress and bed frame replacement on beds where bed rails are used that had been identified in the independent bed survey conducted on June 15, 2011. The plan shall include time frames for completing the work and a plan to ensure the safety of residents while waiting for the mattress replacement to occur. The plan shall be submitted to Michelle Warrener by email to michelle.warrener@ontario.ca by August 26, 2011.

Grounds / Motifs :

1. When bed rails are used, not all steps are taken to prevent resident entrapment, specifically taking into consideration all potential zones of entrapment. On June 14, 2011, it was observed that a number of mattresses were not the appropriate length for the bed frame, including the mattresses for two identified residents. This concern was immediately brought to the attention of the management team. The home had an independent bed survey conducted on June 15, 2011, to assess potential zones of entrapment. During an interview with the Executive Director, on June 20, 2011, it was confirmed that due to the results of the bed survey the home is considering replacing up to 33 mattresses and 5 bed frames due to current bed/mattress configurations presenting potential zones of entrapment. (168)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 26, 2011

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

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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

Order / Ordre :

The licensee shall prepare, submit and implement a plan regarding meeting requirements where a resident is being restrained by a physical device under section 31 of the Act. Include the presence of an order by a physician or registered nurse in the extended class, repositioning of residents and documentation of reassessments of the effectiveness of the restraints completed and documented, and that the resident is monitored at least every hour by staff with corresponding documentation. This plan is to be submitted to Michelle Warrener by email to michelle.warrener@ontario.ca by August 26, 2011.

Grounds / Motifs :

1. Bed rails used to prevent an identified resident from falling from the bed were not ordered by the physician or a registered nurse in the extended class. The plan of care indicates that the resident is to have two bed rails up while in bed, to prevent the resident from falling from the bed. The resident was observed in bed with two bed rails in the up position. Documentation on Point Click Care, Point of Care completed by Personal Support Workers indicates that bed rails were used each shift since June , 2011.
(192)
2. An identified resident was not repositioned at least once every two hours during an observation period greater than two hours on June 24, 2011. The resident was observed reclined in a broda chair that prevented the resident from rising. Between 1109 and 1342 the resident's position was not adjusted. During an interview a Personal Support Worker indicated that the resident was positioned in the chair at approximately 0730 and that the resident's position is changed as often as possible. There is no documentation to support that position changes are occurring at least every two hours.
(192)
3. An identified resident's condition has not been reassessed and the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances. The resident uses two bed rails when in bed to prevent falling out of the bed and is reclined in a broda chair to prevent the resident from rising. The policy related to restraints indicates that registered staff will evaluate the use a restraints each shift and document their evaluation in the progress notes. A review of the progress notes from May 1, 2011 finds that there has been no evaluation of the use of bed rails for this resident. An interview with the Executive Director indicates that bed rails for this resident have not been considered a restraint and the policy has not been adhered to.
(192)
4. An identified resident did not consistently have their condition reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances. The homes restraint policy indicates that registered staff will document the residents condition and the effectiveness of the restraint, each shift a restraint is in use, on the progress notes.
There is no documentation related to the effectiveness of the restraint on 14 shifts during a one week period in June, 2011. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 26, 2011

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REVIEW/APPEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

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 Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-760

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

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

and the

Director

c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Clair Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 9th day of August, 2011

Signature of Inspector / Signature de l'inspecteur : M Warrener

Name of Inspector / Nom de l'inspecteur : MICHELLE WARRENER

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