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
Sep 29, 2016	2016_269627_0013	012728-16	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE TOWN OF KIRKLAND LAKE
3 KIRKLAND STREET WEST POSTAL BAG 1757 KIRKLAND LAKE ON P2N 3P4

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

TECK PIONEER RESIDENCE
145A GOVERNMENT ROAD EAST POSTAL BAG SERVICE 3800 KIRKLAND LAKE ON P2N 3P4

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

SYLVIE BYRNES (627), MARIE LAFRAMBOISE (628), SYLVIE LAVICTOIRE (603)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 30-31, June 1-3 and June 6, 2016.

This inspection included a follow-up to five previous compliance orders (CO) #001, #002 and #003 and CO #001 and #002 related to duty to protect, complying with abuse policy, plan of care and behaviours and one critical incident related to improper transfer and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs), family members and residents.

The Inspectors conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staffing schedules, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **3 WN(s)**
- **1 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_391603_0030	603
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #003	2015_391603_0030	603
O.Reg 79/10 s. 55.	CO #002	2015_391603_0030	603

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. (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 plan of care set out clear directions to staff and others who provided direct care to the resident.

CO#001 was served to the licensee during inspection #2015_391603_0031, November 18, 2015, for failing to comply with LTCH 2007 s.6.(1).

During the course of the inspection, it was identified through a Minimal Data System (MDS) trigger, that a resident had impaired skin integrity for which they were receiving treatment.

Inspector #627 reviewed a written Physician's order for the identified resident which revealed the following:
On a specific date: a procedure to be completed with specific directions. Resident to have a specific type of equipment for a certain time of the day.

A review of the identified resident's most current care plan, under the focus of impaired skin integrity failed to indicate any interventions for the specific type of equipment for a

certain time of the day.

During an interview with the Inspector, the identified resident stated that if the equipment was not within reach, they called the PSW for assistance. The resident further stated that they had forgotten at times to call the PSWs for assistance when the equipment was out of site, therefore, they had not always used the specific type of equipment during a certain time of the day.

During an interview with the Inspector, an RPN stated that the PSWs were responsible for applying the specific type of equipment for a certain time of the day and this should have been written in the care plan, to provide clear directions, as the PSWs did not have access to the Treatment Administration Record (TAR) and were not responsible to review the physician's written orders.

During an interview, the DOC stated that the application of the equipment was the PSW's responsibility and this should have been written in the care plan to provide clear directions to the staff. [s. 6. (1) (c)]

2. 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.

CO#002 was served to the licensee during inspection #2015_391603_0031 on November 18, 2015, for failing to comply with LTCH 2007 s.6.(7).

During the course of the inspection, it was identified through an MDS trigger that a resident had a recent fall.

Inspector #603 reviewed the identified resident's progress notes which revealed that the resident had a fall on three separate dates. The progress notes further indicated that on one of those dates, the resident was found in a specific manner. They sustained a minor injury. At the time of the incident, it was also noted that a specific intervention was not followed.

A review of the plan of care indicated staff were to have completed a specified intervention when the resident was in bed.

During an interview with the Inspector, an RN confirmed that the specific intervention when the resident was in bed was not completed, when the resident sustained a fall. [s.

6. (7)]

3. On a particular day, Inspector #627 observed the dining meal service and noted that a resident was positioned in an unsafe manner, while being assisted with their meal by a PSW.

During an interview, the PSW stated that the identified resident was to be positioned in a specific manner while eating.

A review of the current care plan for the resident, revealed the following intervention for the focus of eating: " resident to be positioned in a different manner while eating to promote optimal meal intake and comfort.

During an interview with the Inspector, the ADOC stated that this was unsafe positioning of the identified resident while being assisted with their meal and that the resident should have been positioned in a different manner.

4. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at any other time when the resident's care needs changed or the care set out in the plan was no longer necessary.

During the inspection, it was identified through an MDS trigger, that a resident had altered skin integrity to a specific area.

On a particular date, Inspector #628 interviewed the identified resident who indicated that they no longer had impaired skin integrity to a specific area.

Inspector #628 observed that the identified resident had no indication of impaired skin integrity to the specific area.

A review of the "Skin Issue Tracking Tool" by the Inspector revealed a notation stating that the identified resident no longer had impaired skin integrity to the specific area.

A review, by the Inspector, of the current care plan, revealed the following interventions for the focus of “Skin integrity”:
Specific interventions to be provided by registered staff for the resident's impaired skin integrity to the specific area.

During an interview with the Inspector, the RPN stated that the interventions for the identified resident's impaired skin integrity remained on the care plan for monitoring purposes.

During an interview with the Inspector, the RAI-MDS Coordinator confirmed that identified resident no longer had impaired skin integrity to the specific area as indicated in the "Teck Pioneer Residence Skin Issues Tracking Tool", and that the care plan should have been updated. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 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. 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 was 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.

During stage one of the inspection, a resident was observed in bed with two half bed rails in the guard position.

Inspector #603 interviewed an RN who explained that the identified resident required two specific interventions, one being the use of bed rails, to prevent injuries.

A review of the identified resident's care plan revealed that the resident required two specific interventions, one being the use of bed rails, to prevent injuries.

A review of the home's Bed Entrapment Prevention Program Policy (undated) revealed that 'when bed rails were used, the resident must be assessed on his/her bed system, must be evaluated in accordance with evidenced-based practices, in order to minimize risks associated with bed rails'.

During an interview with the Administrator, Assistant Director of Care and the Clinical Coordinator, they stated that although the identified resident was assessed, their bed system was not evaluated in accordance with evidence-based practices or in accordance with prevailing practices to minimize risk to the resident. In fact, none of the residents' bed systems were evaluated when bedrails were used.

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 the assessing the use of bed rails.

The CGA identified procedures which included individualized resident assessments, sleeping environment assessments, and care planning guidelines. As well, Health Canada recommended that patients be re-assessed for risk of entrapment whenever there was a change in the patient's medication or physical condition. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 003 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and, where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A resident was identified through an MDS trigger as having had a recent fall.

Inspector #603 reviewed the identified resident's progress notes which revealed that the resident had fallen on three separate dates.

A review of the home's "Falls Prevention and Management Program Policy," last revised October 2015, revealed that 'a fall was any unintentional change in position where the resident ended up on the floor, ground or other lower level'. This included witnessed and un-witnessed falls and whether there was an injury or not. According to the policy, when a resident had fallen, the resident was to be assessed for contributing factors to prevent recurrence, and post-fall documentation including a head to toe assessment, was to be completed.

During an interview with the Inspector, an RN stated that when a resident had fallen, a post-fall screening assessment and a head to toe assessment were required to be completed. They further explained that the post-fall assessment and the head to toe assessment may have been missed for the identified resident's fall, on a particular date, because the resident had actually "rolled out of bed" onto the floor and had not actually fallen. The RN confirmed that there was no post-fall assessment or a head to toe assessment completed for the fall on a specific date. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a specified resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 19th day of October, 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) :	SYLVIE BYRNES (627), MARIE LAFRAMBOISE (628), SYLVIE LAVICTOIRE (603)
Inspection No. / No de l'inspection :	2016_269627_0013
Log No. / Registre no:	012728-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 29, 2016
Licensee / Titulaire de permis :	CORPORATION OF THE TOWN OF KIRKLAND LAKE 3 KIRKLAND STREET WEST, POSTAL BAG 1757, KIRKLAND LAKE, ON, P2N-3P4
LTC Home / Foyer de SLD :	TECK PIONEER RESIDENCE 145A GOVERNMENT ROAD EAST, POSTAL BAG SERVICE 3800, KIRKLAND LAKE, ON, P2N-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nancy Theriault

To CORPORATION OF THE TOWN OF KIRKLAND LAKE, 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_391603_0031, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance ensuring that there is a written plan of care for the identified resident that sets out clear directions to staff and others who provide direct care to the resident. This plan is to include, but not be limited to:

1. The development and implementation of a process to ensure that for the identified resident, a thorough review is conducted of their plan of care to ensure they provide clear direction to staff and others who provide direct care.

2. Ensuring the identified resident's plan of care reflects their needs related to impaired skin integrity.

This plan shall be submitted in writing to Sylvie Byrnes, Long Term Care Homes Nursing Inspector, Long-Term Care Inspection Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or faxed to the inspector's attention, at (705) 564-3133, or email sylvie.byrnes@ontario.ca. This plan must be submitted by October 14, 2016.

Grounds / Motifs :

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

CO#001 was served to the licensee during inspection #2015_391603_0031 on November 18, 2015, for failing to comply with LTCH 2007 s.6.(1).

During the course of the inspection, it was identified through a Minimal Data System (MDS) trigger, that a resident had impaired skin integrity for which they were receiving treatment.

Inspector #627 reviewed a written Physician's order for the identified resident which revealed the following:
On a specific date: a procedure to be completed with specific directions.
Resident to have a specific type of equipment for a certain time of the day.

A review of the identified resident's most current care plan, under the focus of impaired skin integrity failed to indicate any interventions for the specific type of equipment for a certain time of the day.

During an interview with the Inspector, the identified resident stated that if the equipment was not within reach, they called the PSW for assistance. The resident further stated that they had forgotten at times to call the PSWs for assistance when the equipment was out of site, therefore, they had not always used the specific type of equipment during a certain time of the day.

During an interview with the Inspector, an RPN stated that the PSWs were responsible for applying the specific type of equipment for a certain time of the day and this should have been written in the care plan, to provide clear directions, as the PSWs did not have access to the Treatment Administration Record (TAR) and were not responsible to review the physician's written orders.

During an interview, the DOC stated that the application of the equipment was the PSW's responsibility and this should have been written in the care plan to provide clear directions to the staff. [s. 6. (1) (c)]

The decision to re-issue this compliance order was based on the scope which was identified as isolated, the severity which indicated a potential for actual harm and the compliance history.

During an Resident Quality Inspection completed November 2014, under inspection #2014_332575_0021, a written notification and a voluntary plan of correction was issued under the same area of non-compliance. As well, during

an inspection completed October 2015, under inspection #2015_391603_0022, a compliance order (CO) was issued under s. 6 (1).

Despite previous non-compliance, NC continues with this area of the legislation. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_391603_0031, CO #002;

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 prepare, submit and implement a plan for achieving compliance ensuring that care set out in the plan of care is provided to the resident as specified in the plan.
This plan is to include, but not be limited to:

1. The development and implementation of a system to ensure that the care set out in the plans of care are provided to the two identified residents as specified in their plans.

2. Ensuring that corrective actions are taken when care set out in the plan of care is not provided to the resident as specified in the plan.

This plan shall be submitted in writing to Sylvie Byrnes, Long Term Care Homes Nursing Inspector, Long-Term Care Inspection Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or faxed to the attention of the inspector, at (705) 564-3133, or email sylvie.byrnes@ontario.ca. This plan must be submitted by October 15, 2016.

Grounds / Motifs :

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.

CO#002 was served to the licensee during inspection #2015_391603_0031 on November 18, 2015, for failing to comply with LTCH 2007 s.6.(7).

During the course of the inspection, it was identified through an MDS trigger that a resident had a recent fall.

Inspector #603 reviewed the identified resident's progress notes which revealed that the resident had a fall on three separate dates. The progress notes further indicated that on one of those dates, the resident was found in a specific manner. They sustained a minor injury. At the time of the incident, it was also noted that a specific intervention was not followed.

A review of the plan of care indicated staff were to have completed a specified intervention when the resident was in bed.

During an interview with the Inspector, an RN confirmed that the specific intervention when the resident was in bed was not completed, when the resident sustained a fall. [s. 6. (7)]

On a particular day, Inspector #627 observed the dining meal service and noted that a resident was positioned in an unsafe manner, while being assisted with their meal by a PSW.

During an interview, the PSW stated that the identified resident was to be positioned in a specific manner while eating.

A review of the current care plan for the resident, revealed the following intervention for the focus of eating: "resident to be positioned in a different manner while eating to promote optimal meal intake and comfort".

During an interview with the Inspector, the ADOC stated that this was unsafe positioning of the identified resident while being assisted with their meal and that the resident should have been positioned in a different manner.

The decision to re-issue this compliance order was based on the scope which was isolated, the severity which indicated a potential for actual harm and the compliance history.

During an inspection completed September 2014, under inspection #2014_283544_0025, a written notification was issued pursuant to the LTCHA, 2007 S.O. 2007, c.8, s. 6. (7), 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.

During an inspection completed November 2014, under inspection #2014_332575_0021, a written notification and a voluntary plan of correction was issued under the same area of non-compliance.

During an inspection completed June 2015, under inspection #2015_391603_0022, a compliance order (CO) was issued with a compliance date of August 28, 2015, under the same area of non-compliance.

During a follow-up inspection completed October 2015, under inspection #2015_391603_0031, a CO was re-issued with a compliance date of December 11, 2015, and was linked to the previous existing CO.

Despite previous non-compliance, NC continues with this area of the legislation.

(603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall:

1) Develop and implement a process to ensure that where bed rails are used for any reason, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices using the 'Clinical Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings'.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was 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.

During stage one of the inspection, a resident was observed in bed with two half bed rails in the guard position.

Inspector #603 interviewed an RN who explained that the identified resident required two specific interventions, one being the use of bed rails, to prevent injuries.

A review of the identified resident's care plan revealed that the resident required two specific interventions, one being the use of bed rails, to prevent injuries.

A review of the home's Bed Entrapment Prevention Program Policy (undated) revealed that 'when bed rails were used, the resident must be assessed on his/her bed system, must be evaluated in accordance with evidenced-based practices, in order to minimize risks associated with bed rails'.

During an interview with the Administrator, Assistant Director of Care and the Clinical Coordinator, they stated that although the identified resident was assessed, their bed system was not evaluated in accordance with evidence-based practices or in accordance with prevailing practices to minimize risk to the resident. In fact, none of the residents' bed systems were evaluated when bed rails were used.

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 the assessing the use of bed rails.

The CGA identified procedures which included individualized resident assessments, sleeping environment assessments, and care planning guidelines. As well, Health Canada recommended that patients be re-assessed for risk of entrapment whenever there was a change in the patient's medication or physical condition. [s. 15. (1) (a)] (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 14, 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 29th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Byrnes

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