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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HAMILTON, ON, L8P-4Y7
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 3, 2014	2014_189120_0056	H-001011-14	Other

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

BILLINGS COURT MANOR
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): August 27, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Manager, registered staff and personal support workers.

During the course of the inspection, the inspector(s) toured two home areas, observed bed systems, reviewed resident health care records and bed rail use policies and procedures.

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. The licensee did not assess residents who used bed rails in accordance with prevailing practices to minimize risk to the resident.

The licensee commissioned an external company to complete a bed system evaluation of all 160 beds in the home. In August 2013, 80 beds failed one zone of entrapment known as zone 2. The zone is comprised of the space between the bed rail and the side of the mattress. Once the status of the beds was known, the licensee did not proceed to ensure that residents who used a bed rail were assessed for bed rail use and safety risks associated with it`s continued use.

Prevailing practices stem from a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings". The document is endorsed by Health Canada and identifies the need to determine the resident`s mobility, medical background, sleeping habits and other factors to establish the benefits of having one or more bed rails in use when in bed. When a bed has been identified as failing one or more zones of entrapment, the risk of continuing to use the bed rails must be evaluated against the benefits. Alternatives to bed rail use must be tried initially, and if alternatives are not successful, interventions to minimize risk to the resident must then be considered.

During a tour of the home on August 27, 2014, numerous beds were observed to be unoccupied in two separate home areas which had one or more bed rails in the elevated position, ready for use by residents. Personal care workers confirmed that the bed rails were left elevated as a common practice, for residents returning to bed. Other workers stated that the bed rails were used as a comfort measure and to

prevent residents from falling out of bed and some for repositioning and bed mobility.

Three residents were observed lying in bed in 3 identified rooms with one or more bed rails elevated. The Director of Care confirmed that no information was available in the resident's plan of care regarding rail use. Therefore no direction was available for staff to determine whether one or more rails needed to be applied and why. The bed systems, according to the last audit completed in August 2013, identified that the beds in two of the rooms failed entrapment zone 2. Neither resident was observed to have any bed rail pad or bolster in place to reduce the entrapment risk between the mattress and bed rail.

Several other residents reviewed during the inspection were noted to have rail use information in their plans of care, some with a reason and some without. The documentation was inconsistent due to the fact that the registered staff completing the plans did not have a policy or procedure to follow, a form or decision tree to determine how to assess residents, why the resident required one or both rails and whether alternatives were trialled before concluding that a rail was the best option. In addition, an interdisciplinary team was not part of the decision making process. [s. 15(1)(a)]

Additional Required Actions:

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

Issued on this 15th day of September, 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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2014_189120_0056
Log No. / Registre no:	H-001011-14
Type of Inspection / Genre d'inspection:	Other
Report Date(s) / Date(s) du Rapport :	Sep 3, 2014
Licensee / Titulaire de permis :	MARYBAN HOLDINGS LTD 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	BILLINGS COURT MANOR 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lori Turcotte

To MARYBAN HOLDINGS LTD, 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 :

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. Assess all residents who currently reside in a bed system that has failed one or more entrapment zones 1-4 and who use one or more bed rails. The residents shall be assessed according to guidelines set out in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings".
2. The results of the assessments shall be documented so that all staff are aware of the residents who need one or more rails, which rails and why.
3. For residents who were assessed as requiring one or more bed rails, and whose bed system was identified as failing one or more entrapment zones, the risk for the identified entrapment zone shall be mitigated.
3. Educate all registered staff and staff who provide resident care with information identified in the Health Canada document titled " Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards" 2006.

Grounds / Motifs :

1. The licensee did not assess residents who used bed rails in accordance with prevailing practices to minimize risk to the resident.

The licensee commissioned an external company to complete a bed system evaluation of all 160 beds in the home. In August 2013, 80 beds failed one zone of entrapment known as zone 2. The zone is comprised of the space between the bed rail and the side of the mattress. Once the status of the beds was known, the licensee did not proceed to ensure that residents who used a bed rail were assessed for bed rail use and safety risks associated with it`s continued use.

Prevailing practices stem from a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings". The document is endorsed by Health Canada and identifies the need to determine the resident`s mobility, medical background, sleeping habits and other factors to establish the benefits of having one or more bed rails in use when in bed. When a bed has been identified as failing one or more zones of entrapment, the risk of continuing to use the bed rails must be evaluated against the benefits. Alternatives to bed rail use must be tried initially, and if alternatives are not successful, interventions to minimize risk to the resident must then be considered.

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Three residents were observed lying in bed in 3 identified rooms with one or more bed rails elevated. The Director of Care confirmed that no information was available in the resident's plan of care regarding rail use. Therefore no direction was available for staff to determine whether one or more rails needed to be applied and why. The bed systems, according to the last audit completed in August 2013, identified that the beds in two of the rooms failed entrapment zone 2. Neither resident was observed to have any bed rail pad or bolster in place to reduce the entrapment risk between the mattress and bed rail.

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completing the plans did not have a policy or procedure to follow, a form or decision tree to determine how to assess residents, why the resident required one or both rails and whether alternatives were trialled before concluding that a rail was the best option. In addition, an interdisciplinary team was not part of the decision making process. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 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 3rd day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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