Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 4, 5, 6, 10, 11, 12, 13, 17, 18, 19, 24, 2012	2012_083178_0024	Critical Incident

Licensee/Titulaire de permis

ADVENT HEALTH CARE CORPORATION
541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3

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

VALLEYVIEW RESIDENCE
541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3

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

SUSAN LUI (178), BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care (DOC), Senior Nurse Manager, Nurse Manager, Registered Staff, Personal Support Workers (PSWs), Physiotherapist, a resident's family members.

During the course of the inspection, the inspector(s) reviewed resident records, observed residents, observed resident care areas.

The following Inspection Protocols were used during this inspection:

Hospitalization and Death

Minimizing of Restraining

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that identified Resident A's plan of care was based on an interdisciplinary assessment of the resident's safety risks.
Review of the resident's record and staff interviews confirm the following:
-Resident A moved frequently while in bed, and preferred to sleep along the edge of the bed. Partial side rails were used as a fall prevention tool at all times for the resident while in bed.
-The resident was found on at least two occasions prior to his/her death, with his/her upper body out over the edge of the bed, while his/her legs remained on the bed.
-The resident's progress notes from May 17, 2012, state that the resident was found at 0100h with his/her head touching the floor while his/her feet remained on the bed. The progress note further states that the resident is "needing long rails".
-On July 1, 2012 the resident was found by night staff with his/her torso hanging off of the bed, his/her forehead resting on the floor, and his/her right leg still on the bed held in by the partial bed rail. The resident was not breathing and resuscitation efforts were unsuccessful.

Record review and staff interviews reveal that Resident A's plan of care did not address the safety risks identified by night staff in relation to her use of partial bed rails.

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. 15. Bed rails

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. Where bed rails are used, identified Resident A was not assessed and her bed system evaluated in accordance with evidence-based practices to minimize risk to the resident.

On July 1, 2012, a personal support worker conducted a routine bed check of Resident A at approximately 02:45h. The resident was found to be unresponsive and not breathing, with the upper half of his/her body hanging off the side of the bed, his/her forehead resting on the floor and his/her legs along side of the quarter bed rail located half way between the head board and the foot board. The resident passed away shortly thereafter.

According to the Director of Care, Resident A moved frequently while in bed, and preferred to sleep along the edge of the bed. Partial side rails were used as a fall prevention tool at all times for the resident while in bed. Information gathered by inspector #178 on July 6, 2012 revealed that Resident A was found on at least two occasions prior to his/her death, with his/her upper body out over the edge of the bed, while his/her legs remained on the bed.

Resident A's progress notes from May 17, 2012, state that the resident was found at 01:00h with his/her head touching the floor while his/her feet remained on the bed. Staff interviews confirm that the resident's bed rail and bed system were not evaluated to determine if any risks would cause harm to the resident after this incident. The bed rail, which was in place to keep the resident from falling out of bed, was not assessed to determine it's effectiveness. The bed rail continued to be used until July 1, 2012. Alternatives to mitigate the resident's risk of injury from falling out of bed, such as a falls arrest mattress and a bed that can be lowered to the floor were considered, but not implemented.

The home had all of their beds with foam mattresses inspected for entrapment zones on April 15, 2010 by a qualified technician. The home's Environmental Services Supervisor provided a bed audit report that revealed that Resident A's bed and mattress passed the inspection for specific entrapment zones at that time. The therapeutic mattresses in the home have not been assessed or inspected to date. The beds with foam mattresses have not been evaluated since April 15, 2010 to ensure that bed systems (bed frame and mattresses) remain safe where bed rails are used. During the Ministry of Health and Long-Term Care Critical Incident inspection of July 2012, it was noted that 2 mattress keepers (mattress keepers are brackets located at each corner of the bed in order to keep the mattress in place to prevent the mattress from sliding or shifting) were missing from the head deck section of Resident A's bed and the mattress could readily slide from side to side. Several other residents' beds were observed to be missing mattress keepers and the Environmental Services Supervisor reported that none of the beds have all 4 keepers in place.

The Director of Care provided a policy NM-II-B010 titled "Bedside Rails" dated February 2009 which details a procedure for staff to assess the need for bed rails by completing a Bed Rail Assessment Form (013). However, the Director of Care stated that the form has not been used to date and none of the residents have received such an assessment. The policy has not been aligned with evidence-based practices/prevailing practices such as the Health Canada's Guideline titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Reliability and Other Hazards" and does not address what other hazards might present a risk to residents such as the use of therapeutic mattresses.
[O. Reg. 79/10, s.15(1)(a)]

Additional Required Actions:

CO # - 002, 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).
Record review and staff interviews confirm that on the night shift beginning at 23:00h on September 17, 2011, no Registered Nurse (RN) was on duty and present in the home. The home's regularly scheduled RN was ill and the home was unable to replace her with an RN employed by the home or with an agency RN. An agency Registered Practical Nurse (RPN) was called to fill the vacancy. The home's RN on call was made aware that no RN would be present in the home during the shift.
[s.8.(3)]

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following subsections:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits sailiants :

1. The licensee failed to ensure that the policy Restraint Physical & PASD, Chemical and Environmental (NM-II-R008) was complied with.
Staff interviews revealed that staff was using furniture to block gaps in the partial bed rails for identified Resident A in an attempt to prevent the resident from slipping out of the bed and injuring him/herself when he/she pushed him/herself to the head of the bed and around the partial side rail.

The above named policy states that a physical restraint may only be used if ordered by the physician or Registered Nurse in the extended class, details relating to the restraint are included in the plan of care, informed consent has been received by the resident or the SDM (substitute decision maker), the resident's condition and effectiveness of the restraint is reassessed by a physician or registered staff at least every eight hours.
None of these conditions were met in the case of Resident A.
[s.29.(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 to ensure that the home's policy Restraint Physical & PASD, Chemical and Environmental (NM-II-R008) is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a physical device to restrain identified Resident B including all assessment, reassessment and monitoring, is documented.
Restraint Flow Sheet records for Resident B's tilt wheelchair with lap belt and full bed side rails for July do not include signatures by registered staff on six out of eleven day shifts and on three out of ten evening shifts. Night shift has been consistently initialed by the same Registered staff member for ten consecutive nights, although the Registered staff member with those initials worked only five shifts in July.
Restraint Flow Sheets for July for Resident B's tilt wheelchair with lap belt and his/her full bed side rails were not completed by PSW staff on the day shift on July 2, 2012.
[r.110.(7)6.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that once in every calendar year an evaluation is conducted to determine the effectiveness of the restraint policy.
It was confirmed by the DOC that the home's policy Restraint:Physical & PASD, Chemical and Environmental (NM-II-R008) is not evaluated annually to determine the effectiveness of the policy and identify what changes and improvements are required to minimize restraining and ensure that restraining is done in accordance with the Act and Regulation.
[r.113.(b)]

WN #7: 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 subsections:

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 failed to ensure that a resident is restrained by a physical device only if the restraining of the resident is included in the resident's plan of care.
Staff interviews revealed that night staff was using furniture to block openings around Resident A's partial rails when the resident was in bed. Staff members stated that they felt this measure was necessary to prevent the resident from slipping out of the bed and injuring him/herself when he/she pushed him/herself to the head of the bed and around the partial side rail.
Resident A's plan of care does not include the use of any restraint.
[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 to ensure that a resident is restrained by a physical device only if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director under the Long-Term Care Homes Act (LTCHA) was immediately informed of an unexpected or sudden death, including a death resulting from an accident or suicide.
At approximately 03:00h on July 1, 2012 identified Resident A was found by staff unresponsive and not breathing, with his/her upper body hanging partially out of the bed. 911 was called but resuscitation attempts were unsuccessful. The coroner attended the scene and ruled the cause of death to be an accident.
The Director under the LTCHA was not informed of the unexpected death until July 4, 2012, when a Critical Incident report was submitted by the home.
[r.107.(1)2.]

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Issued on this 15th day of August, 2012

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

Susan Sui (178)

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) :	SUSAN LUI (178), BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2012_083178_0024
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jul 4, 5, 6, 10, 11, 12, 13, 17, 18, 19, 24, 2012
Licensee / Titulaire de permis :	ADVENT HEALTH CARE CORPORATION 541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3
LTC Home / Foyer de SLD :	VALLEYVIEW RESIDENCE 541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MIKE SAVATOVICH

To ADVENT HEALTH CARE CORPORATION, you are hereby required to comply with the following order(s) by the date (s) set out below:

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

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. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall ensure that the plans of care for all residents requiring the use of side rails are based on an interdisciplinary assessment of each resident's safety risks.

Grounds / Motifs :

1. The licensee has failed to ensure that an identified resident's plan of care was based on an interdisciplinary assessment of the resident's safety risks.

Review of the resident's record and staff interviews confirm the following:

-The identified resident moved frequently while in bed, and preferred to sleep along the edge of the bed. Partial side rails were used a a fall prevention tool for the resident at all times while in bed.

-The resident was found on at least two occasions prior to the resident's death, with his/her upper body out over the edge of the bed while his/her legs remained on the bed.

-The resident's progress notes from May 17, 2012, state that the resident was found at 0100h with his/her head touching the floor while his/her feet remained on the bed. The progress note further states that the resident is "needing long rails".

-On July 1, 2012 the resident was found by night staff with his/her torso hanging off of the bed, his/her forehead resting on the floor, and his/her right leg still on the bed held in by the partial bed rail. The resident was not breathing and resuscitation efforts were unsuccessful.

Record review and staff interviews reveal that the identified resident's plan of care did not address the safety risks identified by night staff in relation to his/her use of partial bed rails. (178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

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. 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 to ensure mattress keepers are installed according to manufacturer's instructions on all residents' beds. Please submit the plan to Bernadette Susnik at bernadette.susnik@ontario.ca by August 31, 2012.

Grounds / Motifs :

1. Where bed rails are used, an identified resident was not assessed and his/her bed system evaluated in accordance with evidence-based practices to minimize risk to the resident.

On July 1, 2012, a personal support worker conducted a routine bed check of the resident at approximately 02:45h. The resident was found to be unresponsive and not breathing, with the upper half of his/her body hanging off the side of the bed, his/her forehead resting on the floor and his/her legs along side of the quarter bed rail located half way between the head board and the foot board. The resident passed away shortly thereafter.

According to the Director of Care, the resident moved frequently while in bed, and preferred to sleep along the edge of her bed. Partial side rails were used as a fall prevention tool at all times for the resident while in bed. Information gathered by inspector #178 on July 6, 2012 revealed that the resident was found on at least two occasions prior to his/her death, with his/her upper body out over the edge of the bed, while his/her legs remained on the bed.

The resident's progress notes from May 17, 2012, state that the resident was found at 01:00h with his/her head touching the floor while his/her feet remained on the bed. Staff interviews confirm that the resident's bed rail and bed system were not evaluated to determine if any risks would cause harm to the resident after this incident. The bed rail, which was in place to keep the resident from falling out of bed, was not assessed to determine it's effectiveness. The bed rail continued to be used until July 1, 2012. Alternatives to mitigate the resident's risk of injury from falling out of bed, such as a falls arrest mattress and a bed that can be lowered to the floor were considered, but not implemented.

The home had all of their beds with foam mattresses inspected for entrapment zones on April 15, 2010 by a qualified technician. The home's Environmental Services Supervisor provided a bed audit report that revealed that the identified resident's bed and mattress passed the inspection for specific entrapment zones at that time. The therapeutic mattresses in the home have not been assessed or inspected to date. The beds with foam mattresses have not been evaluated since April 15, 2010 to ensure that bed systems (bed frame and mattresses) remain safe where bed rails are used. During the Ministry of Health and Long-Term Care Critical Incident inspection of July 2012, it was noted that 2 mattress keepers (mattress keepers are brackets located at each corner of the bed in order to keep the mattress in place to prevent the mattress from sliding or shifting) were missing from the head deck section of the identified resident's bed and the mattress could readily slide from side to side. Several other residents' beds were observed to be missing mattress keepers and the Environmental Services Supervisor reported that none of the beds have all 4 keepers in place.

The Director of Care provided a policy NM-II-B010 titled "Bedside Rails" dated February 2009 which details a procedure for staff to assess the need for bed rails by completing a Bed Rail Assessment Form (013). However, the Director of Care stated that the form has not been used to date and none of the residents have received such an assessment. The policy has not been aligned with evidence-based practices/prevailing practices such as the Health Canada's Guideline titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Reliability and Other Hazards" and does not address what other hazards might present a risk to residents such as the use of therapeutic mattresses. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

Order # /
Ordre no : 003

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

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

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 to ensure that all residents requiring bed rails are assessed for the risks associated with bed rail use. Please submit the plan to Bernadette Susnik at bernadette.susnik@ontario.ca by August 31, 2012.

Grounds / Motifs :

1. Where bed rails are used, an identified resident was not assessed and his/her bed system evaluated in accordance with evidence-based practices to minimize risk to the resident.

On July 1, 2012, a personal support worker conducted a routine bed check of the resident at approximately 02:45h. The resident was found to be unresponsive and not breathing, with the upper half of his/her body hanging off the side of the bed, his/her forehead resting on the floor and his/her legs along side of the quarter bed rail located half way between the head board and the foot board. The resident passed away shortly thereafter.

According to the Director of Care, the resident moved frequently while in bed, and preferred to sleep along the edge of the bed. Partial side rails were used as a fall prevention tool at all times for the resident while in bed. Information gathered by inspector #178 on July 6, 2012 revealed that the resident was found on at least two occasions prior to his/her death, with his/her upper body out over the edge of the bed, while his/her legs remained on the bed.

The resident's progress notes from May 17, 2012, state that the resident was found at 01:00h with his/her head touching the floor while his/her feet remained on the bed. Staff interviews confirm that the resident's bed rail and bed system were not evaluated to determine if any risks would cause harm to the resident after this incident. The bed rail, which was in place to keep the resident from falling out of bed, was not assessed to determine it's effectiveness. The bed rail continued to be used until July 1, 2012. Alternatives to mitigate the resident's risk of injury from falling out of bed, such as a falls arrest mattress and a bed that can be lowered to the floor were considered, but not implemented.

The home had all of their beds with foam mattresses inspected for entrapment zones on April 15, 2010 by a qualified technician. The home's Environmental Services Supervisor provided a bed audit report that revealed that the identified resident's bed and mattress passed the inspection for specific entrapment zones at that time. The therapeutic mattresses in the home have not been assessed or inspected to date. The beds with foam mattresses have not been evaluated since April 15, 2010 to ensure that bed systems (bed frame and mattresses) remain safe where bed rails are used. During the Ministry of Health and Long-Term Care Critical Incident inspection of July 2012, it was noted that 2 mattress keepers (mattress keepers are brackets located at each corner of the bed in order to keep the mattress in place to prevent the mattress from sliding or shifting) were missing from the head deck section of the identified resident's bed and the mattress could readily slide from side to side. Several other residents' beds were observed to be missing mattress keepers and the Environmental Services Supervisor reported that none of the beds have all 4 keepers in place.

The Director of Care provided a policy NM-II-B010 titled "Bedside Rails" dated February 2009 which details a procedure for staff to assess the need for bed rails by completing a Bed Rail Assessment Form (013). However, the Director of Care stated that the form has not been used to date and none of the residents have received such an assessment. The policy has not been aligned with evidence-based practices/prevailing practices such as the Health Canada's Guideline titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Reliability and Other Hazards" and does not address what other hazards might present a risk to residents such as the use of therapeutic mattresses.

~~J (120)~~

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

Order # /
Ordre no : 004

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 to ensure that where bed rails are used, all residents' bed systems are evaluated according to evidence based practices/prevailing practices to prevent entrapment and minimize risk to residents. Please submit the plan to Bernadette Susnik at bernadette.susnik@ontario.ca by August 31, 2012.

Grounds / Motifs :

1. Where bed rails are used, an identified resident was not assessed and his/her bed system evaluated in accordance with evidence-based practices to minimize risk to the resident.

On July 1, 2012, a personal support worker conducted a routine bed check of the resident at approximately 02:45h. The resident was found to be unresponsive and not breathing, with the upper half of his/her body hanging off the side of the bed, his/her forehead resting on the floor and his/her legs along side of the quarter bed rail located half way between the head board and the foot board. The resident passed away shortly thereafter.

According to the Director of Care, the resident moved frequently while in bed, and preferred to sleep along the edge of the bed. Partial side rails were used as a fall prevention tool at all times for the resident while in bed. Information gathered by inspector #178 on July 6, 2012 revealed that the resident was found on at least two occasions prior to his/her death, with his/her upper body out over the edge of the bed, while his/her legs remained on the bed.

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The Director of Care provided a policy NM-II-B010 titled "Bedside Rails" dated February 2009 which details a procedure for staff to assess the need for bed rails by completing a Bed Rail Assessment Form (013). However, the Director of Care stated that the form has not been used to date and none of the residents have received such an assessment. The policy has not been aligned with evidence-based practices/prevailing practices such as the Health Canada's Guideline titled "Adult Hospital Beds: Entrapment Hazards, Side Rail Latching Reliability and Other Hazards" and does not address what other hazards might present a risk to residents such as the use of therapeutic mattresses. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

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

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 & Compliance Branch
Ministry of Health & Long-Term Care
1075 Bay Street, 11th Floor, Suite 1100
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

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

and the

Director
c/o Appeals Coordinator
Performance Improvement & Compliance Branch
Ministry of Health & Long-Term Care
1075 Bay Street, 11th Floor, Suite 1100
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.

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 24th day of July, 2012

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SUSAN LUI

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