Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 14, 2015	2015_344586_0013	H-002967-15	Resident Quality Inspection

Licensee/Titulaire de permis

PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE
72 Town Centre Drive Townsend ON N0A 1S0

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

GARDENVIEW LONG TERM CARE HOME
72 Town Centre Drive Townsend ON N0A 1S0

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

JESSICA PALADINO (586), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 27, 28, 29, 31 and August 4, 5, 6 and 7, 2015.

The following inspections were completed during simultaneously with this Resident Quality Inspection;
Follow-up Inspections: H-002341-15 [redacted] error to Sept 2015
Critical Incident Inspections: H-001759-14, H-002091-15 and H-002934-15.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO)/Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Program Services Manager (PSM), Physiotherapist (PT), dietary aides, housekeeping and maintenance staff, personal support workers (PSWs), Registered nurses (RNs), Registered practical nurses (RPNs), recreation staff, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

7 WN(s)
4 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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 has failed to ensure that when bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #001 was observed in bed with bed rails in use on July 28, 2015. Interview with the ADOC confirmed the resident used bed rails while in bed for safety. A review of the resident's written plan of care did not include an assessment of the bed rails being used. Interview with the ADOC and RAI Co-ordinator on August 4, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place.

B) Resident #009 was observed in bed with bed rails in use on August 6, 2015. Interview with a PSW and review of the written plan of care confirmed the resident used bed rails while in bed for safety. A review of the resident's written plan of care did not include an assessment of the bed rails being used. Interview with the ADOC and RAI Co-ordinator on August 4, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place.

C) Resident #004 was observed in bed with a bed rail in use on August 4, 2015. Interview with a PSW confirmed the resident used a bed rail while in bed for mobility. A review of the resident's written plan of care did not include an assessment of the bed rail being used or included that the resident used the rails for positioning or mobility. Interview with the ADOC on August 4, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place.

The ADOC and RAI Co-ordinator indicated that the home had not assessed residents in their bed systems when bed rails were in use, and confirmed that the home did not have a formalized assessment completed for the use of bed rails for all residents in the home. [s. 15. (1) (a)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (6) When a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44. 2007, c. 8, s. 6 (6).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident was assessed and an initial plan of care developed based on that assessment and on the assessment, re-assessments and information provided by the placement co-ordinator under section 44. 2007, c.8, s. 6(6).

Resident #005 was admitted to the home on an identified date in 2015 with multiple pressure areas. As provided for in the regulations, each resident is to be assessed in order to develop their initial plan of care within 14 days of the resident's admission to the home. The RD did not complete the initial RD Admission Assessment and identify the level of nutritional risk for the resident until 39 days after the resident's admission. This was confirmed through record review and interview with the RD on August 6, 2015. [s. 6. (6)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in their plan.

Resident #004's plan of care directed staff to use bed rails in a specified manner while the resident was in bed. An observation of the resident on August 4, 2015, confirmed that the resident had the rails raised in a manner that did not match the direction in their plan of care. Interview conducted with the registered staff on August 4, 2015 confirmed that the staff did not follow the resident's plan of care. [s. 6. (7)]

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 resident is admitted to a long-term care home, the resident is assessed and the initial plan of care developed under section 44.; and to ensure that the care set out in each resident's plan of care is provided to the residents as specified in their plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's use of a PASD was included in the resident's plan of care.

Resident #001 was observed using an identified PASD on July 28, 2015. Interview with a registered staff member and a PSW confirmed that the resident used the PASD at specific times of the day. A review of the resident's health record and written plan of care

did not include the use of the PASD. This was confirmed by the ADOC and PT. [s. 33. (3)]

2. The licensee has failed to ensure that alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with routine activity of living.

A) Resident #009 was observed using a specific PASD on July 28, 2015. Interview with the PT and review of the resident's written plan of care confirmed that the resident used the PASD at specific times of the day. A review of the resident's health record did not include an assessment of the resident's need for the use of the PASD. This was confirmed by the RAI Co-ordinator.

B) Resident #001 was observed using a specific PASD on July 28, 2015. Interview with a registered staff member and a PSW confirmed that the resident used the PASD at specific times of the day. A review of the resident's health record did not include an assessment of the resident's need for the use of the PASD. [s. 33. (4) 1.]

3. The licensee has failed to ensure that each resident's use of a PASD had been approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

A) Resident #001 was observed using a specific PASD on July 28, 2015. Interview with a registered staff member and a PSW confirmed that the resident used the PASD at specific times of the day. A review of the resident's health record did not include an approval for the use of the PASD by any persons listed in the regulation. Interview with the PT on August 5, 2015, confirmed that an assessment and approval should have been completed for the use of the PASD.

B) Resident #009 was observed using a specific PASD on July 28, 2015. Review of the resident's written plan of care confirmed that the resident used the PASD at specific times of the day. A review of the resident's health record did not include an approval for the use of the PASD by any persons listed in the regulation.

C) Resident #101 was observed using a specific PASD on August 6, 2015. Interview with the PT and review of the resident's written plan of care confirmed that the resident used the PASD at specific times of the day. A review of the resident's health record did

not include an approval for the use of the PASD by any persons listed in the regulation. [s. 33. (4) 3.]

4. The licensee has failed to ensure that the use of the PASD had been consent to by the resident, or if the resident is incapable, a substitute decision-maker (SDM) of the resident with authority to give that consent.

A) Resident #001 was observed using a specific PASD on July 28, 2015. Interview with a registered staff member and a PSW confirmed that the resident used the PASD at specific times of the day. A review of the resident's health record did not include consent for the use of the PASD by the resident`s SDM. Interview with the PT on August 5, 2015, confirmed that a consent form should have been completed by the resident`s SDM for the use of the PASD. [s. 33. (4) 4.]

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 each resident's use of a PASD is included in their plan of care; to ensure that alternatives to the use of a PASD have been considered for each resident's PASD use, and tried where appropriate; and to ensure that each resident's use of a PASD has been approved by a physician, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was posted.

During a tour of the home on August 4, 2015, the home's policy to promote zero tolerance of abuse and neglect to residents could not be located in conspicuous and easily accessible areas of the home. On August 7, 2015, the CEO/DOC confirmed that this information was not posted anywhere in the home. [s. 79. (3) (c)]

2. The licensee has failed to ensure that the policy to minimize the restraining of residents was posted and communicated, as well as information about how a copy of the policy could be obtained.

During a tour of the home on August 4, 2015, posting of the policy to minimize the restraining of residents could not be located in conspicuous and easily accessible areas of the home. On August 7, 2015, the CEO/DOC confirmed that this information was not posted anywhere in the home. [s. 79. (3) (g)]

3. The licensee has failed to ensure the most recent minutes of the Family Council meetings, with the consent of the Family Council.

During a tour of the home on August 4, 2015, posting of the most recent Family Council meetings could not be located in conspicuous and easily accessible areas of the home. On August 7, 2015, the CEO/DOC confirmed that this information was not posted anywhere in the home. [s. 79. (3) (o)]

4. The licensee failed to ensure that an explanation of whistle-blowing protections related to retaliation was posted.

During a tour of the home on August 4, 2015, posting of an explanation of whistle-blowing protections related to retaliation could not be located in conspicuous and easily accessible areas of the home. On August 7, 2015, the CEO/DOC confirmed that this information was not posted anywhere in the home. [s. 79. (3) (p)]

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 policy to promote zero tolerance of abuse and neglect of residents, the policy to minimize the restraining of residents (including information on how a copy of the policy can be maintained), the most recent Family Council meeting minutes, and an explanation of whistle-blowing protections related to retaliation were posted in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident,

or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

O. Reg. 79/10, s. 107 (4).

2. A description of the individuals involved in the incident, including,

i. names of any residents involved in the incident,

ii. names of any staff members or other persons who were present at or discovered the incident, and

iii. names of staff members who responded or are responding to the incident.

O. Reg. 79/10, s. 107 (4).

3. Actions taken in response to the incident, including,

i. what care was given or action taken as a result of the incident, and by whom,

ii. whether a physician or registered nurse in the extended class was contacted,

iii. what other authorities were contacted about the incident, if any,

iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and

v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 107 (4).

4. Analysis and follow-up action, including,

i. the immediate actions that have been taken to prevent recurrence, and

ii. the long-term actions planned to correct the situation and prevent recurrence.

O. Reg. 79/10, s. 107 (4).

5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

A) Resident #102 sustained an injury and was transferred to the hospital on an identified date in 2014, resulting in a significant change in condition. The Director was not notified of the incident until six business days after the incident occurred.

B) The home submitted six Critical Incident System (CIS) Notifications to the Director between November 22, 2013 and July 17, 2015. Amendment requests were not responded to by the home as of August 6, 2015. This was confirmed by the CEO/DOC. [s. 107. (3)]

2. The licensee has failed to ensure that the Director was informed of an incident under subsection (1), (3) or (3.1) within 10 days in writing.

Resident #009 sustained a fall on an identified date in 2015, with a significant change in condition. The licensee notified the Director by phone three days later to inform that the incident occurred; however, failed to submit a written report including the detailed information required in the legislation as of August 7, 2015. The CEO/DOC confirmed that CIS report was not submitted to the Director. [s. 107. (4)]

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 Director is informed of any incident that causes injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition no later than one business day after the occurrence of the incident; and to ensure the Director is informed of any incident under subsection (1), (3) or (3.1) within 1- days in writing, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's plan of care was based on an interdisciplinary assessment that included the resident's continence level including bowel elimination.

Resident #007's plan of care did not address the resident's continence level for bowel elimination. The RAI Co-ordinator confirmed that the resident did not have a plan of care to address resident's continence level for bowel management or had interventions in place for the staff to follow. [s. 26. (3) 8.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey
Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council was sought out in developing and carrying out the satisfaction survey.

Interviews with the Residents' Council President and Residents' Council Assistant on August 4, 2015, confirmed that the advice of the Council was not sought out in developing and carrying out the home's satisfaction survey on an annual basis. [s. 85. (3)]

Issued on this 14th day of August, 2015

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

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PALADINO (586), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2015_344586_0013
Log No. / Registre no:	H-002967-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 14, 2015
Licensee / Titulaire de permis :	PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE 72 Town Centre Drive, Townsend, ON, N0A-1S0
LTC Home / Foyer de SLD :	GARDENVIEW LONG TERM CARE HOME 72 Town Centre Drive, Townsend, ON, N0A-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARA DI BIASE

To PARKVIEW MEADOWS CHRISTIAN RETIREMENT VILLAGE, 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. 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 complete the following:
1. All residents who use a bed rail shall be assessed for bed rail use by employing the guidelines identified in the FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
2. The result of the assessment shall be documented in the residents' plan of care and the information regarding the resident's bed rail use (which side of bed, size of rail, how many rails and why) shall be clearly identified so that health care staff have clear direction.
3. All health care workers shall receive education on the hazards of bed rail use.

Grounds / Motifs :

1. The licensee has failed to ensure that when bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #001 was observed in bed with rails in use on July 28, 2015. Interview with the ADOC confirmed the resident used bed rails while in bed for safety. A review of the resident's written plan of care did not include an assessment of the bed rails being used. Interview with the ADOC and RAI Co-ordinator on August 4, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place.

B) Resident #009 was observed in bed with rails in use on August 6, 2015. Interview with a PSW and review of the written plan of care confirmed the resident used bed rails while in bed for safety. A review of the resident's written plan of care did not include an assessment of the bed rails being used. Interview with the ADOC and RAI Co-ordinator on August 4, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place.

C) Resident #004 was observed in bed with a rail in use on August 4, 2015. Interview with a PSW confirmed the resident used a bed rail while in bed for mobility. A review of the resident's written plan of care did not include an assessment of the bed rail being used or included that the resident used the rails for positioning or mobility. Interview with the ADOC on August 4, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place. (506)

The ADOC and RAI Co-ordinator indicated that the home had not assessed residents in their bed systems when bed rails were in use, and confirmed that the home did not have a formalized assessment completed for the use of bed rails for all residents in the home. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 13, 2015

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 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

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

and the Director

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 14th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Paladino

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