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
Jan 27, 2015	2014_168202_0028	T-1563-14, T-1492-14	Complaint

Licensee/Titulaire de permis

THE ONTARIO MISSION OF THE DEAF
2395 BAYVIEW AVENUE NORTH YORK ON M2L 1A2

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

BOB RUMBALL HOME FOR THE DEAF
1 Royal Parkside Drive BARRIE ON L4M 0C4

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

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 17, 18, 22, 2014 and January 08, 2015.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), assistant director of care (ADOC), resident care manager (RCM), physiotherapist (PT), dietitian, registered nursing staff, personal support workers.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

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

Resident #01's plan of care identified the resident as having an end stage condition and required total staff assistance for all aspects of care. Staff interviews indicated that the resident was required to be elevated at 45 degrees or higher at all times while in bed. Staff indicated that the resident preferred to lie on his/her side at a 90 degree incline, both for comfort and to watch television. Staff indicated that the resident had two ¼ length bed rails that were used to support the resident when providing him/her personal care and to hold pillows that were used to position the resident in any of the above mentioned positions. The bed side rails were removed on an identified date, following a bed rail assessment, by the RCM. Staff indicated that without the support of the side rails, they could not elevate the resident lying on his/her side greater than 45 degrees, as the resident may fall out of bed.

A review of the written plan of care for resident #01, indicated that when the resident is in bed, the bed to be in the lowest position to the floor. The written plan of care, however, did not provide any direction to staff regarding the resident's bed mobility and required positioning while the resident is in bed. Interviews with both the ADOC and the DOC

confirmed the above. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Resident #01's plan of care identified the resident as having an end stage condition and required total staff assistance for all aspects of care. Staff interviews indicated that the resident was required to be elevate at 45 degrees or higher while in bed and that the resident preferred to lay in a side lying position at 90 degrees, both for comfort and to be able to watch television. Staff indicated that the resident had two ¼ length bed rails that were used to support the resident when providing his/her personal care and to hold pillows that were used to position the resident in any of the above mentioned positions. Staff indicated that without the side rails in place, they were unable to position the resident in a side lying position greater than 45 degrees. Staff indicated that the resident was at high risk of falling out of bed without the positioning support of pillows.

A review of resident #01's clinical records indicated that a bed rail assessment was conducted on an identified date by the RCM. A review of the bed rail assessment indicated that the resident did not use the bed rails and was at no risk for falling. The RCM recommended that the bed rails be removed, the resident's bed be placed at the lowest position and mats be placed on either side of the bed when the resident is in bed.

Staff interviews indicated that the resident's bed rails were removed on an identified date, during the day shift, with no explanation to staff as to why. A review of the progress notes indicated that later that night, an identified registered nurse documented a request that the resident's bed rails be reinstated. The RN indicated that the removal of the bed rails was a huge safety concern for the resident, as the resident may slide out of bed and choke on mucous build up. Staff indicated that the resident could no longer be elevated above 45 degrees, nor could the resident be supported on his/her side. Staff indicated that attempts were made to position the resident at the desired elevation, however, the pillows used to support the resident while in bed would fall off the bed and onto the floor.

An interview with an identified RN indicated that on the night shift after the bed rails had been removed, he/she wrote a letter of concern regarding the removal of the resident's bed rails. The RN documented in the letter the potential safety risks identified for resident #01 and for three other residents in the home.

A review of the progress notes for resident #01 indicated that three days after the removal of the bed rails on the night shift, the resident had become ill. The notes indicated that the resident was assessed and that the resident was unable to be left on his/her side as there were no bed rails on bed; however, the resident was left on his/her back at 45 degrees. The progress notes for the resident indicated that the resident's health began to deteriorate over the next two days. The notes further indicated that the resident's neck had been propped with a pillow to give some height as the resident still did not have bed rails to keep him/her from falling out of bed if he/she were raised too high. The progress notes indicated that a letter had been sent to the RCM requesting the reapplication of the resident's bed rails to prevent aspiration and a fall last week.

On this same day, the physician notes indicated that the resident had declined and that the resident's condition was terminal. A review of the bed rail assessment form documented by the DOC and dated this same day, indicated that staff have requested bed rails to be back on the resident's bed. The request has been granted as staff indicated they need the bed rails to support the resident when they turn him/her to provide personal care, otherwise the bed rails were not needed. An interview with the RCM indicated that bed rails were put back on the resident's bed the following day and the resident passed away two days later.

Interviews with the ADOC and DOC confirmed receipt of the above mentioned letter, however, only became aware of the letter five days after the bed rails had been removed, through a telephone meeting with an identified RN. The DOC indicated that resident #01's bed rails were removed because the resident did not need them according to the bed rail assessment conducted earlier by the RCM. The RCM indicated in an interview that a bed rail assessment had been conducted for every resident in the home. The RCM indicated that staff had been consulted prior to the removal of the bed rails. The RCM indicated that if staff required the use of the bed rails to assist in providing personal care to residents, the side rails were removed, in order to minimize the use of side rails as restraints. The RCM indicated that the bed rail assessment did not include any aspects of the resident's bed mobility and positioning requirements. [s. 6. (4) (b)]

3. A review of resident #04's clinical records indicated that a bed rail assessment had been conducted on an identified date by the RCM for the use of ¼ length bed rails. A review of the bed rail assessment indicated that the resident had requested bed rails, is unable to walk, does not get into bed often, however, likes to use the bed rails to assist with transfers into the lounge chair.

Staff interviews indicated that the resident's bed rails were removed on an identified date, with no indication as to why. An interview with a RN indicated that he/she had documented a progress note on this same day, requesting that the resident's bed rails be put back on the bed because the resident is unable to move and reposition him/herself while in bed. Direct care staff interviews indicated that the resident had used the bed rails for bed mobility which allowed him/her to sit up right at the side of the bed maintaining his/her independence. [s. 6. (4) (b)]

4. A review of resident #03's clinical records indicated that a bed rail assessment had been conducted on an identified date by the RCM for use of the two ¼ length bed rails. A review of the bed rail assessment indicated that the resident is at no risk of falling and that the resident's bed should be in lowest position to the floor and bed rails removed. Staff interviews indicated that the resident's bed rails were removed on an identified date with no indication as to why. An interview with a RN indicated that he/she documented in a progress note on the same day, requesting that the resident's bed rails be reinstated as there was a huge safety concern with him/her sliding out of bed and choking on mucous buildup. Staff indicated that the resident requires pillows for repositioning and has breathing difficulties if the head of the bed is not elevated. Staff indicated that pillows were used to support the resident's positioning, and the pillows were supported by the bed rails. The bed rails were placed back on the resident's bed six days later, through staff request.

Ten direct care staff were interviewed and indicated that they had not been consulted regarding resident #01, #03 and #04's use of the bed rails or associated safety risks. An interview with the physiotherapist indicated that although, he/she provides physiotherapy assessments and desired treatment for residents, he/she does not assess residents for the safety risks associated with bed rails and bed mobility. Interviews with the ADOC and DOC confirmed that the development and implementation of the above mentioned resident plans of care, in respect to the use of bed rails, bed mobility and the safe positioning of the residents while in bed had not been developed and integrated collaboratively with all staff. The DOC indicated that after the on-site inspection had completed, an assessment form had been developed and implemented to ensure that all staff are involved in the development and implementation of each resident's plan of care. [s. 6. (4) (b)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Bed Rail policy, #NUR-V-308, dated June 2014, is complied with.

The home's above mentioned policy indicated that bed rails should only be prescribed where there is risk of the bed occupant falling out of bed and or/when providing bed rails is considered to be the safest way forward. The decision to use or not use bed rails, is the responsibility of the registered staff/DOC/ADOC and should be clearly documented in the resident's plan of care.

A review of resident #04's clinical records indicated that a bed rail assessment was conducted on an identified date by the RCM for use of two ¼ length bed rails. A review of the bed rail assessment indicated that the resident wants bed rails, does not often get into bed but likes to use the bed rails to assist with transfers into his/her lounge chair. The RCM further documented in a progress note on an identified date, that the resident has two bed rails in the number one position; he/she seldom sleeps in his/her bed, ambulates in his/her room and prefers to sleep in his/her lounge chair, therefore, it is recommended the bed rails to be removed at this time. Staff interviews indicated that the bed rails were removed on an identified date, with no reason provided as to why. Staff indicated that without the 1/4 length bed rails, the resident was unable to move

him/herself in bed and could no longer transfer from his/her bed to lounge chair. [s. 8. (1) (a)]

2. A review of resident #03's clinical records indicated that a bed rail assessment was conducted on an identified date by the RCM for use of two ¼ length bed rails. A review of the bed rail assessment indicated that the resident is at no risk of falling and that the resident's bed should be in lowest position to the floor and bed rails removed. Staff interviews indicated that the resident's bed rails were removed on an identified date, with no indication as to why. An interview with a RN indicated that he/she documented in a progress note the same day, requesting that the resident's bed rails be reinstated as there was a huge safety concern with him/her sliding out of bed and choking on mucous buildup. Staff indicated that the resident required pillows for repositioning and a medical condition that worsens if the head of his/her bed is not elevated. Staff indicated that pillows were used to support the resident's positioning, and the pillows were supported by the bed rails. The bed rails were placed back on the resident's bed on six days later, through staff request. [s. 8. (1) (b)]

3. A review of resident #01's clinical records indicated that a bed rail assessment was conducted on an identified date by the RCM for use of two ¼ length bed rails. A review of the bed rail assessment indicated that the resident is at no risk for falling, the resident does not use bed rails and bed should be at the lowest position. Staff interviews indicated that the resident's bed rails were removed on an identified date. An identified RN indicated in an interview that he/she documented in a progress note requesting that the resident's bed rails be reinstated as the resident needs the bed rails. The RN indicated that was a huge safety concern because the resident could slide out of bed and/or choke on mucous buildup. Staff indicated that the resident had an end stage condition and required pillows for repositioning and had difficulty breathing if the head of his/her bed was not elevated at or above 45 degrees. Staff indicated that they used pillows to support the resident in an elevated position while in bed and the pillows were supported by the bed rails. Without the bed rails, the pillows fell to the floor and the resident could no longer maintain a side lying elevated position.
The progress notes indicated that on the night shift three days after the bed rails were removed, the resident had become ill. The notes indicated that the resident was unable to be left on his/her side as there were no bed rails on the bed; however, he/she was left back lying in a high elevated position.

The bed rail assessment documentation form, dated five days after the bed rails had been removed, by the DOC, indicated that staff requested resident #01's bed rails be

placed back on the resident's bed. The documentation further indicated that the request from staff had been granted because staff needed the bed rails to support the resident when providing him/her personal care, otherwise, the bed rails are not needed. An interview with the RCM indicated that bed rails were put back on the resident's bed the following day.

A review of resident #01, #03, and #04's plan of care did not include any documentation to support the reasons for the decisions made for the actual use or no use of bed rails. Interviews with the ADOC and the RCM indicated that although the RCM followed the bed rail assessment matrix as directed by the home's bed rail policy, both confirmed that there was no documentation to support the reason in which the above mentioned resident bed rails were to be used or not used and the associated risks. [s. 8. (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 Bed Rail policy, #NUR-V-308, dated June 2014, is complied with, to be implemented voluntarily.

WN #3: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of the safety risks with respect to the resident.

A review of resident #01's clinical records indicated that the resident had an end stage condition and required total staff assistance for all aspects of care. Direct care staff interviews and registered staff interviews indicated that the resident had difficulty breathing if the head of his/her bed was not elevated at 45 degrees or higher.

Staff indicated that the resident had two ¼ length bed rails in place at the centre of the bed. Staff indicated that the side rails were used to provide care to the resident and to support pillows that were used to position the resident in an elevated side lying position due to his/her medical condition. Staff indicated that without the side rails, they were unable to position the resident lying on his/her side greater than 45 degrees, as he/she would be at risk of falling out of bed.

A review of resident #01's clinical records indicated that a bed rail assessment was conducted on an identified date by the RCM for use of the two ¼ length bed rails. A review of the bed rail assessment indicated that the resident was at no risk for falling and the resident did not use the rails, therefore, the bed rails are to be removed and the bed be at the lowest position to the floor. The resident's bed rails were removed on an identified date. An interview with a registered staff indicated that he/she documented a note in the progress notes the same day, requesting that the resident's bed rails be reinstated as there were huge safety concerns of the resident sliding out of bed and choking on mucous buildup. Staff indicated that without the use of the ¼ length bed rails that were used to support the pillows, the resident could not be positioned lying on his/her side greater than 45 degrees.
On an identified date, the DOC documented on the resident's bed rail assessment form, that staff requested bed rails to be placed back on the bed. The request was granted as staff indicated they need the bed rails to support the resident when they turn him/her in bed for personal care, otherwise bed rails were not needed. An interview with the DOC indicated that staff requested the bed rails to be put back on the bed after they had been removed to assist with personal care. The DOC indicated that the decision to remove the bed rails was based on the bed rail assessment conducted previously by the RCM, however, confirmed that the bed rail assessment did not include and assessment of the the resident's mobility or safety risks associated with bed rails.

A review of the plan of care for resident #01 did not include an assessment of the safety risks identified for the resident, which should have included; risk for choking, proper positioning while in bed and the use of bed rails. The DOC confirmed that the risks identified above had not been assessed and included in the resident's plan of care. [s. 26. (3) 19.]

WN #4: 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:

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 has failed to ensure that the restraint by a physical device is included in the plan of care.

The plan of care for resident #03 indicated that the resident requires his/her bed to be in the lowest position when he/she is in bed and bed rails have been removed. On December 18 and 22, 2014, the inspector observed the resident to be in bed, lying on his/her back at 45 degrees with two 1/4 length bed rails raised. Staff interviews indicated that the resident is unable to reposition him/herself. The side rails are used to reposition the resident and to prevent the resident from falling out of bed. Staff indicated that the use of the bed rails are considered a restraint for this resident and had not been included in the resident's plan of care. [s. 31. (1)]

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:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class.

On December 18 and 22, 2014, the inspector observed resident #03 to be in bed, lying on his/her back at a 45 degree elevation with two 1/4 length side rails raised. Staff interviews indicated that the resident is unable to reposition him/herself. The side rails are used to reposition the resident and to maintain a 45 degree elevation. Staff indicated that the side rails are used to prevent the resident from falling out of bed when the bed is elevated. Registered staff and direct care staff interviews indicated that the use of the bed side rails for resident #03 are a restraint and confirmed that the bed side rail restraint have not been ordered by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

2. The licensee has failed to ensure that the resident monitored at least every hour while restrained by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff.

On December 18 and 22, 2014, the inspector observed resident #03 to be in bed, lying on his/her back at a 45 degree incline with two 1/4 length bed rails raised. Staff interviews indicated that the resident is unable to reposition him/herself. The side rails are used to reposition the resident and to maintain a 45 degree elevation. Staff indicated that the side rails are used to prevent the resident from falling out of bed when the bed is elevated. Registered staff and direct care staff interviews indicated that the use of the bed side rails for resident #03 are a restraint and confirmed that the resident is not monitored at least every hour while restrained by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff. [s. 110. (2) 3.]

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

Issued on this 2nd day of February, 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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2014_168202_0028
Log No. / Registre no:	T-1563-14, T-1492-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 27, 2015
Licensee / Titulaire de permis :	THE ONTARIO MISSION OF THE DEAF 2395 BAYVIEW AVENUE, NORTH YORK, ON, M2L-1A2
LTC Home / Foyer de SLD :	BOB RUMBALL HOME FOR THE DEAF 1 Royal Parkside Drive, BARRIE, ON, L4M-0C4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shirley Cassel

To THE ONTARIO MISSION OF THE DEAF, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. The plan should include, but not be limited to ensuring that all staff participate in the development and implementation of the plan of care so that the different aspects of care, including resident safety risks, bed mobility, positioning while in bed, and the use or no use of bed rails are included.

Please submit the plan to valerie.johnston@ontario.ca by February 27, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A review of resident #03's clinical records indicated that a bed rail assessment had been conducted on an identified date by the RCM for use of the two ¼ length bed rails. A review of the bed rail assessment indicated that the resident is at no risk of falling and that the resident's bed should be in lowest position to the floor and bed rails removed. Staff interviews indicated that the resident's bed

rails were removed on an identified date with no indication as to why. An interview with a RN indicated that he/she documented in a progress note on the same day, requesting that the resident's bed rails be reinstated as there was a huge safety concern with him/her sliding out of bed and choking on mucous buildup. Staff indicated that the resident requires pillows for repositioning and has breathing difficulties if the head of the bed is not elevated. Staff indicated that pillows were used to support the resident's positioning, and the pillows were supported by the bed rails. The bed rails were placed back on the resident's bed six days later, through staff request. (202)

2. A review of resident #04's clinical records indicated that a bed rail assessment had been conducted on an identified date by the RCM for the use of ¼ length bed rails. A review of the bed rail assessment indicated that the resident had requested bed rails, is unable to walk, does not get into bed often, however, likes to use the bed rails to assist with transfers into the lounge chair.
Staff interviews indicated that the resident's bed rails were removed on an identified date, with no indication as to why. An interview with a RN indicated that he/she had documented a progress note on this same day, requesting that the resident's bed rails be put back on the bed because the resident is unable to move and reposition him/herself while in bed. Direct care staff interviews indicated that the resident had used the bed rails for bed mobility which allowed him/her to sit up right at the side of the bed maintaining his/her independence. (202)

3. Resident #01's plan of care identified the resident as having an end stage condition and required total staff assistance for all aspects of care. Staff interviews indicated that the resident was required to be elevate at 45 degrees or higher while in bed and that the resident preferred to lay in a side lying position at 90 degrees, both for comfort and to be able to watch television. Staff indicated that the resident had two ¼ length bed rails that were used to support the resident when providing his/her personal care and to hold pillows that were used to position the resident in any of the above mentioned positions. Staff indicated that without the side rails in place, they were unable to position the resident in a side lying position greater than 45 degrees. Staff indicated that the resident was at high risk of falling out of bed without the positioning support of pillows.

A review of resident #01's clinical records indicated that a bed rail assessment was conducted on an identified date by the RCM. A review of the bed rail

assessment indicated that the resident did not use the bed rails and was at no risk for falling. The RCM recommended that the bed rails be removed, the resident's bed be placed at the lowest position and mats be placed on either side of the bed when the resident is in bed.

Staff interviews indicated that the resident's bed rails were removed on an identified date, during the day shift, with no explanation to staff as to why. A review of the progress notes indicated that later that night, an identified registered nurse documented a request that the resident's bed rails be reinstated. The RN indicated that the removal of the bed rails was a huge safety concern for the resident, as the resident may slide out of bed and choke on mucous build up. Staff indicated that the resident could no longer be elevated above 45 degrees, nor could the resident be supported on his/her side. Staff indicated that attempts were made to position the resident at the desired elevation, however, the pillows used to support the resident while in bed would fall off the bed and onto the floor.

An interview with an identified RN indicated that on the night shift after the bed rails had been removed, he/she wrote a letter of concern regarding the removal of the resident's bed rails. The RN documented in the letter the potential safety risks identified for resident #01 and for three other residents in the home.

A review of the progress notes for resident #01 indicated that three days after the removal of the bed rails on the night shift, the resident had become ill. The notes indicated that the resident was assessed and that the resident was unable to be left on his/her side as there were no bed rails on bed; however, the resident was left on his/her back at 45 degrees. The progress notes for the resident indicated that the resident's health began to deteriorate over the next two days. The notes further indicated that the resident's neck had been propped with a pillow to give some height as the resident still did not have bed rails to keep him/her from falling out of bed if he/she were raised too high. The progress notes indicated that a letter had been sent to the RCM requesting the reapplication of the resident's bed rails to prevent aspiration and a fall last week.

On this same day, the physician notes indicated that the resident had declined and that the resident's condition was terminal. A review of the bed rail assessment form documented by the DOC and dated this same day, indicated that staff have requested bed rails to be back on the resident's bed. The request

has been granted as staff indicated they need the bed rails to support the resident when they turn him/her to provide personal care, otherwise the bed rails were not needed. An interview with the RCM indicated that bed rails were put back on the resident's bed the following day and the resident passed away two days later.

Interviews with the ADOC and DOC confirmed receipt of the above mentioned letter, however, only became aware of the letter five days after the bed rails had been removed, through a telephone meeting with an identified RN. The DOC indicated that resident #01's bed rails were removed because the resident did not need them according to the bed rail assessment conducted earlier by the RCM. The RCM indicated in an interview that a bed rail assessment had been conducted for every resident in the home. The RCM indicated that staff had been consulted prior to the removal of the bed rails. The RCM indicated that if staff required the use of the bed rails to assist in providing personal care to residents, the side rails were removed, in order to minimize the use of side rails as restraints. The RCM indicated that the bed rail assessment did not include any aspects of the resident's bed mobility and positioning requirements.

Ten direct care staff were interviewed and indicated that they had not been consulted regarding resident #01, #03 and #04's use of the bed rails or associated safety risks. An interview with the physiotherapist indicated that although, he/she provides physiotherapy assessments and desired treatment for residents, he/she does not assess residents for the safety risks associated with bed rails and bed mobility. Interviews with the ADOC and DOC confirmed that the development and implementation of the above mentioned resident plans of care, in respect to the use of bed rails, bed mobility and the safe positioning of the residents while in bed had not been developed and integrated collaboratively with all staff. The DOC indicated that after the on-site inspection had completed, an assessment form had been developed and implemented to ensure that all staff are involved in the development and implementation of each resident's plan of care. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

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 27th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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