



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
prévus 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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4^{ème} étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Sep 27, 28, Oct 15, 16, 2012	2012_178102_0001	Follow up

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South, WHITBY, ON, L1N-9W2

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

STRATHAVEN LIFECARE CENTRE
264 King Street East, Bowmanville, ON, L1C-1P9

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

WENDY BERRY (102)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, several staff, several residents and visitors.

During the course of the inspection, the inspector(s) followed up on 4 compliance orders related to resident safety; checked privacy curtains in residents' rooms; checked door security systems; toured resident areas on the 1st, 2nd and lower levels. 3 Compliance Orders related to the door security systems have been complied with. 1 Compliance Order related to bed systems has been issued again with a new compliance date. The on site inspection was conducted on September 27 and 28, 2012.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 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. O. Reg 79/10, s. 15(1)(a) identifies that where bed rails are used, a resident's bed system is to be evaluated in accordance with evidence based practices or with prevailing practices, to minimize risk to the resident.
2. Evidence based prevailing practices are identified in Health Canada's Guidance Document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".
3. During the course of an inspection in the home on May 24, 2012, potential zones of entrapment were identified on 6 of 6 residents' bed systems that were measured on the 2nd floor of the home: bed rails with an open space of greater than 120 mm (4 3/4 inches) within the inner perimeter of the rail are in use in rooms as identified. Protective covers were not in use on the bed rails that were measured. In a discussion related to the residents' beds, the home's previous Administrator identified that residents' bed systems had been evaluated and that entrapment zones had been identified. It was further identified that action had not been taken and none was planned to mitigate the potential entrapment risks that were identified as a result of the evaluation that had been done. A Compliance Order was issued with a date for compliance set as July 16, 2012.
4. On September 27 and 28, 2012 a follow up inspection was conducted. Compliance order (CO) #004 had not been complied with. Potential zones of entrapment as identified during the inspection conducted on May 24, 2012 and as noted in CO #004 remained present.
5. The current Administrator of the home and the Director of Care provided documentation that all residents' bed systems were evaluated for entrapment hazards during August 2012. Documentation was also provided identifying that entrapment prevention barriers were ordered on September 26, 2012 for all bed systems identified to have zone 1 to 4 entrapment zone risks. The barriers were not in place at the time of the inspection on September 27 and 28, 2012.
6. Steps were not taken to minimize risk to the resident and prevent possible resident entrapment, taking into consideration all potential zones of entrapment, by the compliance order date of July 16, 2012. The order has been issued again with a revised date for compliance. [s. 15.(1)(b)]



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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. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. Sufficient privacy curtains to provide privacy are not provided in a number of shared resident bedrooms:
 - in a number of bedrooms, access into an ensuite washroom has not been separated from a nearby resident's bed space (example: rooms identified etc.) ;
 - in a number of bedrooms, privacy curtains are not provided on all sides of stationary and non stationary overhead lifts so that resident privacy can be maintained at all times(example: rooms identified, etc.);
 - room identified is occupied by 4 residents; privacy curtains are insufficient to enclose one of the four beds.

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 every shared resident room is equipped with sufficient privacy curtains around each bed to provide privacy to every resident of the room, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT
CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 r. 9.	CO #001, #002, #003	2012_028102_0028	102
O.Reg 79/10 r. 9.	CO #001, #002, #003	2012_028102_0028	102
O.Reg 79/10 r. 9.	CO #001, #002, #003	2012_028102_0028	102
O.Reg 79/10 r. 16.	WN #1	2012_028102_0028	102

WB
WB

Issued on this 16th day of October, 2012



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

A handwritten signature in cursive script, appearing to read "Andy Bees", is written within a rectangular box.



**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

**Ministère 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) :	WENDY BERRY (102)
Inspection No. / No de l'inspection :	2012_178102_0001
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Sep 27, 28, Oct 15, 16, 2012
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, WHITBY, ON, L1N-9W2
LTC Home / Foyer de SLD :	STRATHAVEN LIFECARE CENTRE 264 King Street East, Bowmanville, ON, L1C-1P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PATRICK BROWN MILDRED JARVIS

To Glen Hill Terrace Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:



**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
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Order # /
Ordre no : 001

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

Linked to Existing Order /
Lien vers ordre existant: 2012_028102_0028, CO #004

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 will ensure that all appropriate steps are taken to mitigate any risks to residents where the beds and bed rails do not meet the requirements as identified in Health Canada's Guidance Document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".

Grounds / Motifs :

1. O. Reg 79/10, s. 15(1)(a) identifies that where bed rails are used, a resident's bed system is to be evaluated in accordance with evidence based practices or with prevailing practices, to minimize risk to the resident.
2. Evidence based prevailing practices are identified in Health Canada's Guidance Document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".
3. During the course of an inspection in the home on May 24, 2012, potential zones of entrapment were identified on 6 of 6 residents' bed systems that were measured on the 2nd floor of the home: bed rails with an open space of greater than 120 mm (4 3/4 inches) within the inner perimeter of the rail are in use in rooms as identified. Protective covers were not in use on the bed rails that were measured. In a discussion related to the residents' beds, the home's previous Administrator identified that residents' bed systems had been evaluated and that entrapment zones had been identified. It was further identified that action had not been taken and none was planned to mitigate the potential entrapment risks that were identified as a result of the evaluation that had been done. A Compliance Order was issued with a date for compliance set as July 16, 2012.
4. On September 27 and 28, 2012 a follow up inspection was conducted. Compliance order (CO) #004 had not been complied with. Potential zones of entrapment as identified during the inspection conducted on May 24, 2012 and as noted in CO #004 remained present.
5. The current Administrator of the home and the Director of Care provided documentation that all residents' bed systems were evaluated for entrapment hazards during August 2012. Documentation was also provided identifying that entrapment prevention barriers were ordered on September 26, 2012 for all bed systems identified to have zone 1 to 4 entrapment zone risks. The barriers were not in place at the time of the inspection on September 27 and 28, 2012.
6. Steps were not taken to minimize risk to the resident and prevent possible resident entrapment, taking into consideration all potential zones of entrapment, by the compliance order date of July 16, 2012. The order has been issued again with a revised date for compliance. [s. 15.(1)(b)] (102)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012



**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

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Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
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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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.



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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 16th day of October, 2012

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

WENDY BERRY

Service Area Office /

Bureau régional de services : Ottawa Service Area Office