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

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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
Mar 23, 2015	2015_337581_0003	H-001934-15	Resident Quality Inspection

Licensee/Titulaire de permis

BLACKADAR CONTINUING CARE CENTRE INC.
101 CREIGHTON ROAD DUNDAS ON L9H 3B7

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

BLACKADAR CONTINUING CARE CENTRE
101 CREIGHTON ROAD DUNDAS ON L9H 3B7

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

DIANNE BARSEVICH (581), LEAH CURLE (585), LISA VINK (168), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 29, 30 and February 3, 4, 5, 6, 10, 11, 12, 2015.

This inspection report includes the inspections completed related to H-001696-14, H-001787-14, H-001979-15 and follow ups to, H-00260-14 and H-00261-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered nurses(RN), Registered Practical Nurses(RPN), Resident Assessment Instrument (RAI) Coordinator, Corporate Nurse Consultant, Personal Support Workers (PSW), Physiotherapist(PT), Program Manager, Dietitian, Food Service Manager(FSM), Environmental Service Supervisor(ESS), Dietary staff, Maintenance staff, families and residents.
The inspectors during this inspection toured the home, observed meal service, and care practices, reviewed clinical health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
24 WN(s)
14 VPC(s)
3 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 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) A review of resident #012's written plan of care indicated they required the use of two quarter bed rails in the raised position for bed mobility and repositioning when in bed. Interviews with the RPN and PSW's confirmed the resident's bed rails were raised when in bed. Review of the resident's written plan of care did not include an assessment of the bed rails being used. The registered staff confirmed that the home did not have a formalized assessment for the use of bed rails in place.

B) According to the home's maintenance files, all bed systems in the home were inspected for entrapment risk to residents on February 3, 2014; however, 34 of 79 bed systems failed in at least one zone of entrapment. According to the Administrator, steps were taken to address the failed zones of entrapment; however, a facility entrapment inspection sheet dated April 9 and 10, 2014, indicated that only 14 of the 34 failed beds had been reassessed and passed the inspection. The Administrator could not confirm that the remaining 20 beds were free of entrapment risk to residents.

On February 10, 2015, the following beds that had failed zones of entrapment on February 3, 2014 and were not reassessed on April 9 and 10, 2014, were observed to have residents laying in them with bed rails in the raised position:

i) Bed #42 failed entrapment risk in zone two. A resident was observed laying in bed #42 with two half bed rails in the raised position;
ii) Bed #74 failed entrapment risk in zones two, three and four. A resident was observed laying in bed #74 with two quarter bed rails in the raised position; and
iii) Bed #50 failed entrapment risk in zone two. A resident was observed laying in bed #50 with two three quarter bed rails in the raised position.

The Administrator could not confirm that these beds had been assessed and evaluated to minimize risk to these residents.

C) On two identified dates in January 2015, resident #010 was observed laying in bed with two three quarter bed rails in the raised position. The resident had a diagnosis of uncontrolled movements and limited mobility. Review of the resident's plan of care indicated they had been using bed rails for bed mobility for at least the past year; however, this review also revealed they had not been assessed in their bed system to minimize the risk to the resident. Registered staff and the RPN who assisted the DOC confirmed that resident #010 had not been assessed in their bed system to minimize the risk to the resident.

D) On specified dates in January and February 2015, resident #025 was observed laying in bed with two three quarter bed rails in the raised position. Review of the resident's plan of care indicated that the resident had been using bed rails for bed mobility for at least the past year; however, this review also revealed they had not been assessed in their bed system to minimize the risk to the resident. Registered staff and the RPN who assisted the DOC confirmed that resident #025 had not been assessed in their bed system to minimize the risk to the resident.(526) [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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a physical device was applied in accordance with the manufacturer's instructions.

The home's "Resident Care Quality Indicators" policy for "Physical Restraints" reference number RESI-10-01-01 last reviewed November 2012, included but was not limited to directing staff to ensure that the restraint was appropriately applied. The policy included the manufacturer's "Pelvic Support User's Guide" and the vendor's "Belt Application for Proper Positioning" which directed staff to apply the lap belt "not too loose to allow client to slide under belt...just enough space for two fingers to fit between the belt and pelvic crest". The home's policy for "Consent for Restraint Use" reference number RESI-10-01-03 last reviewed November 2012, indicated that death from strangulation was a risk associated with physical restraints.

A) Staff confirmed that resident #010 had a diagnosis of uncontrolled movements and limited mobility. The resident's plan of care and staff interviews confirmed that the resident had a lap belt applied while sitting in their wheelchair to prevent the resident from falling in the event that they had uncontrolled movements.

On an identified date in January 2015, at approximately 1000 hours resident #010 was observed sitting in their wheelchair with a lap belt applied 20 centimeters from the resident's torso. A registered practical nurse (RPN) confirmed that the lap belt was loose but could not state the manufacturer's recommended tightness of the lap belt application. The RPN attempted to tighten the lap belt but could not and stated that the vendor would need to make the adjustment. The RRN left the resident unattended with the lap belt loose across the resident's torso.

At 1030 hours, the resident's lap belt continued to be loose and the resident was unattended by staff.

At 1040 hours the LTC Inspector informed the Administrator that the resident's lap belt was loose and he confirmed that the lap belt posed a risk to the resident given their health condition and history.

At 1100 hours, approximately 20 minutes after the Administrator was informed of the risk to resident #010, the resident was observed in the dining room sitting in their wheelchair with the loosened lap belt, positioned with their back to the door while closely surrounded by several residents. An RPN confirmed that it would be difficult to attend to the resident if they began to have uncontrolled movements in their wheelchair and confirmed that the resident's lap belt was loose.

At 1115 hours, the Administrator stated that the vendor had been contacted and would be in the home to adjust resident #010's lap belt some time that day. The Administrator confirmed that the resident's safety had to be addressed immediately.

At approximately 1130 hours, resident #010 was observed sitting in an alternate wheelchair with a lap belt that was applied with two finger widths between the belt and the resident's torso.

During an interview with the LTC Inspector, the RAI Coordinator confirmed that resident #010's lap belt was loose on an identified date in January 2015, and stated that it would be difficult to tell how long the belt had been applied unsafely. They confirmed that staff were supposed to be checking the resident's restraint hourly for safety and that the application of the lap belt should be part of this safety check.

B) On an identified date in January 2015, at approximately 1010 hours, resident #031 was observed sitting in their wheelchair with lap belt applied so that it was positioned at least four finger widths between the lap belt and the resident's torso. A RPN inspected the lap belt and stated that it was positioned correctly.

At 1035 hours, the resident's lap belt continued to be loose and the resident was unattended by staff. The RPN stated they had not repositioned the lap belt.

At 1040 hours the LTC Inspector informed the Administrator that the resident's lap belt was loose and he confirmed that the lap belt posed a risk to the resident.

At 1100 hours, approximately 20 minutes after the Administrator was informed of the risk

to resident #031, the resident was observed sitting in the hallway with the lap belt positioned two finger widths between the belt and the resident's torso. The Administrator stated that the Director of Care (DOC) came and adjusted the resident's lap belt. [s. 110. (1) 1.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, with in respect of each of the interdisciplinary programs required under section 48 of this Regulation, each program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Review of the home's program evaluation files revealed that the home had not evaluated the following programs:
i) Falls prevention and management
ii) Skin and wound care
iii) Continence care and bowel management

The DOC confirmed that these programs had not been evaluated in 2014. [s. 30. (1) 3.]

Additional Required Actions:

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

WN #4: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for resident #015 set out the planned care for the resident.

Resident #015 used personally supplied pull-ups during the day as part of their continence management. The resident's kardex and written plan of care listed they used

medium briefs at all times and the resident profile worksheet used by PSW's stated the resident used "SR" briefs in the day, evening and night. Multiple PSW's and registered nursing staff all reported that the resident used pull-ups in the day and confirmed the written plan of care did not include the pull-ups. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A) Resident #010 had a diagnosis of uncontrolled movements and limited mobility. The resident's Resident Assessment Instrument Minimum Data Set (RAI MDS) completed November 2014, indicated that the resident had a trunk restraint applied daily. The associated Resident Assessment Protocol (RAP) indicated that the resident used a lap belt on a daily basis "to prevent sliding out of their chair during uncontrolled movements. The uncontrolled movements are unpredictable and of varying intensity and duration... will care plan to minimize the risks associated with using restraints". The document the home referred to as resident #010's "care plan" indicated that the resident required the lap belt to prevent falling out of the wheelchair with uncontrolled movements and that staff should check the resident's lap belt every hour for safety. The care plan did not provide direction on how to minimize the risk associated with using the restraint as indicated in the RAP.
On an identified date in January 2015, resident #010 was observed sitting in their chair with a lap belt applied 20 centimeters from the resident's torso. A registered staff confirmed that the lap belt was loose but could not state the recommended tightness of the lap belt application. Registered staff and the RAI Coordinator confirmed that the resident's plan of care did not provide clear direction to staff regarding the application of resident #010's restraint to minimize risks associated with using restraints for the resident. (526)

B) Two signs located above resident #023's bed directed staff to transfer the resident using "side-by-side transfer" and "two person with sit/stand mechanical lift as needed". A physiotherapist assessment note on an identified day in December 2014, stated the resident's transfer status was "2 person assist side by side", and "mechanical sit to stand as needed with two person assist". The resident's kardex and care plan stated "2 staff to transfer onto toilet with sit-stand", revised April 2013. Two PSW's reported that the resident status had improved over the past several months, and required side-by-side transfer when toileting. PSW's and Registered nursing staff confirmed the plan of care did not provide clear direction to staff who provide direct care to the resident. (585)

C) Review of resident #024's health record indicated that they had two catheters. The document the home referred to as resident #024's care plan directed staff to attend to one of the catheters every four hours and no direction in relation to the other catheter. RPN and PSW staff stated they would only attend to both catheters when the resident would ask for assistance.

During interview with the LTC Inspector, resident #024 became tearful when stating that they were afraid that staff wouldn't attend to their catheter in a timely manner because the resident was afraid that the bags would overflow and leak. The resident stated that they had to wait for staff to come to attend their catheters, there had been times when the bags had overflowed and they informed the LTC Inspector that "this made them feel terrible".

A RPN confirmed that the plan of care for resident #024 did not provide clear direction to staff attending to the resident's catheters. (526)

D) The written plan of care and most recent MDS assessment indicated that resident #018 required the assistance of two staff for all transfers. Interviews with the PSW's and the PT stated the resident was a one person transfer. The bedside logo directed staff to transfer the resident with one person, which was the current assistance being provided. Registered staff and the PSW's confirmed there were no clear directions for the transfer of the resident in and out of bed. (581)

E) The written plan of care indicated that the resident #022 required extensive assistance of one staff to provide personal hygiene which included brushing their dentures. PSW stated the resident only had one upper denture and no teeth. During interviews a PSW stated that mouth care was provided using a lemon glycerine swabstick and another PSW stated they provided mouth care using mouth wash. Registered staff and the PSW's confirmed there were no clear directions for providing mouth and oral care. (581) [s. 6. (1) (c)]

3. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

During interview with the LTC inspector on an identified date in January 2015, resident #011 stated that they did not like to have a shower and would prefer to have a bath. Progress notes indicated that the resident refused their shower on an identified day in February, 2015. When interviewed by LTC Inspector, a PSW indicated that the resident

would refuse their shower often; the PSW stated that they had not considered to offer a bath instead. Interviews with PSWs and RPNs who worked regularly with resident #011 indicated that the resident had requested they have a bath instead of a shower, but that staff were concerned if the tub chair lift and tub would accommodate the resident's needs. These staff indicated that the resident had not been assessed in terms of their bathing preferences and whether the home's bathing facilities could meet the resident's needs. [s. 6. (2)]

4. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

A) Resident #010's RAI MDS completed November, 2014, indicated that the resident used bed rails for mobility and transfer. The resident had a diagnosis of uncontrolled movements and limited mobility. On two identified dates in January 2015, resident #010 was observed in bed with two three quarter bed rails in the raised position. PSW staff interviewed confirmed they raised the bed rails when the resident was in bed. Registered and PSW staff confirmed that the resident did not use the bed rails for mobility but rather, for safety in the event that the resident had uncontrolled movements. The RAI Coordinator confirmed that staff did not collaborate with each other in the assessment of the resident regarding their use of bed rails.

B) Resident #016's RAI MDS assessment completed on January 2015, indicated that the resident had abrasions and bruises. The associated RAP indicated that the resident did "not have any skin issues". Review of progress notes and skin assessments indicated that the resident did not have alteration of skin integrity during the seven days of observation that contributed to the RAI assessment completed on January 2015. This was confirmed by the RPN responsible for treatments in the home. The RPN and the RAI Coordinator confirmed that staff had not collaborated on their assessments of resident #016's skin integrity.

C) The MDS assessment completed on July 2014, identified resident #040 was to be transferred with limited assistance and two person physical assist. The written plan of care during that same period of time indicated they were transferred with limited assistance with one staff. DOC confirmed the resident was a two person transfer and that staff had not collaborated on their assessments of the resident's transfers. (581) [s. 6. (4) (a)]

5. The licensee failed to ensure that the care set out in resident #023's plan of care was provided as specified in the plan.

Resident #023 had a plan of care to have their dentures cleaned in the morning during care, and after every meal. The resident reported they could not recall how often they received assistance from staff with oral hygiene and cleaning. Review of the resident's flow sheets indicated the resident did not receive oral care five times in January and once in February 2015.

A PSW reported the resident required assistance during morning care and after meals and stated the resident would request assistance from staff after meals for oral care. The PSW stated that if documentation was incomplete, the home's interpretation was that care was not provided. This was confirmed by Registered nursing staff and the DOC. (585) [s. 6. (7)]

6. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.

A) According to resident #011's Multi Monthly Participation Report for the resident's recreation activity participation, the resident attended 274 activities between August 1, 2014 and February 4, 2015. Interviews with staff indicated that the resident liked attending recreation programs and did so frequently. The resident told the LTC Inspector that they enjoyed evening programs and required assistance to attend. The resident stated there were times when they had to tell PSW staff that they wanted to attend so that staff wouldn't start the resident's bedtime care.

Review of the document the home referred to as resident #011's "care plan" completed December 2014, indicated that the resident had "little or no involvement, lack of attendance" in organized recreation. The care plan did not indicate that the resident enjoyed all programs including evening programs and that the resident was to be assisted to bed after they had returned from the program. During interview with the LTC Inspector, the Program Manager stated that the resident's care needs had changed in that the resident used to refuse programs and did not want to attend. The Program Manager confirmed that resident's plan of care had not been updated when resident #011's care needs changed (526)

B) Review of the written plan of care for resident #020 indicated they wore briefs. Interview with the resident and PSW staff stated they were continent of both bowel and

bladder and did not use continence products. Registered staff confirmed the resident had not worn briefs for over a year and that the plan of care was not revised when the resident's care needs changed. (581)

C) Review of the written plan of care for resident #020 indicated the sit stand lift was used to transfer them from wheelchair or bed to shower chair. The resident and the PSW's both stated they were transferred with one person assist and used the railing. Registered staff confirmed that the plan of care was not revised when the resident's care needs changed. (581)

D) The document the home referred to as resident #021's "care plan" completed February 2015, indicated that the resident had altered skin integrity on their abdomen and received treatment. The electronic treatment administration record (eTAR) indicated that the treatment the resident received ended on an identified day in January 2015. A PSW and the RPN responsible for treatments in the home confirmed that the resident no longer had the altered skin integrity on their abdomen. The RPN confirmed that the resident's plan of care was not updated when the plan was no longer necessary. (526)

E) Review of the written plan of care for resident #012 indicated that they were an extensive assistance of one staff for transferring in and out of bed. Interviews with PSW's and review of the flow sheets indicated they were transferred with two person physical assistance from bed to wheelchair and back. Registered staff confirmed that the plan of care was not revised and reviewed when the resident's care needs changed. (581)

F) Review of resident #016's health record indicated that their nutritional risk was increased from medium to high risk. Review of dietary progress note written by the Food Services Manager on an identified date in January 2015, indicated that resident #016 had a decreased appetite, was refusing meals, had a ten percent decrease in body weight in the past six months, and was below a healthy weight range in relation to body mass index. The RAP completed on January 2015 confirmed these observations.

The document the home referred to as resident #016's "care plan" completed on an identified day in January 2015, indicated that the resident was a moderate nutritional risk and had not changed since the resident's previous care plan completed on an identified day in October 2014. The resident's electronic medication record indicated that the resident was receiving dietary interventions that began on an identified day in September 2014 and had not been updated as of February 2015. The dietitian confirmed that plan

of care had not changed or updated to address the resident's increase in nutritional risk. (526)

G) Review of the written plan of care for resident #018 indicated they needed to be reminded to brush their dentures; however, the most recent MDS assessment identified they were extensive assistance of one staff for personal hygiene which included oral care. A PSW stated the resident was extensive assistance of one staff for oral and denture care. Registered staff confirmed that the plan of care was not reviewed and revised when the resident's oral care needs changed. (581)

H) Review of the written plan of care for resident #018 indicated they needed assistance of one staff to the washroom and may need to be pushed on a commode to return to bed. PSW's stated they were toileted at bedside with a commode or walked to and from the washroom. Registered staff confirmed that the plan of care was not reviewed and revised when the resident's toileting needs changed. (581)

I) Resident #040 fell on an identified day in November 2014 and sustained an injury. Review of the written plan of care completed on an identified day in December 2014, indicated they required limited assistance of one staff for bed mobility; however, the PSW flow sheets identified that the resident was extensive assistance with two staff post injury. The DOC confirmed that the care plan was not reviewed and revised when the resident's care needs changed post injury. (581) [s. 6. (10) (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 plan of care sets out the planned care for the resident, sets out clear directions to staff and others who provide direct care to the resident, the plan of care is based on an assessment of the resident and the resident's needs and preferences, that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, the care set out in resident plan of care is provided as specified in the plan and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 9. Restorative care

Findings/Faits saillants :

1. The licensee failed to ensure that there was an organized interdisciplinary program with a restorative care philosophy that, (a) promoted and maximized independence; and (b) where relevant to the resident's assessed care needs, included, but was not limited to, physiotherapy and other therapy services which were either arranged or provided by the licensee.

The home's policy for the "Restorative Nursing Program" number 01-01 last reviewed March 2011, indicated that the home had an organized restorative care program. During interview with Long Term Care(LTC) inspector on February 6, 2015, the physiotherapist, RAI Coordinator and corporate nurse consultant confirmed that the home did not have an organized interdisciplinary restorative care program. The corporate consultant confirmed that the home's policy was not being implemented. [s. 9.]

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 there was an organized interdisciplinary program with a restorative care philosophy that promoted and maximized independence and where relevant to the resident's assessed care needs, included, but was not limited to, physiotherapy and other therapy services which were either arranged or provided by the licensee, to be implemented voluntarily.

WN #6: 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 failed to ensure that a PASD described in subsection (1) that was used to assist a resident with a routine activity of living was included in the resident's plan of care.

Resident #010 had a diagnosis of uncontrolled movements and limited mobility. The resident's RAI MDS completed November 2014, indicated that the resident used bed

rails for mobility and transfer. The associated RAP did not include an assessment or planning regarding the use of bed rails for the resident. The document the home referred to as resident #010's "care plan" completed December 2014, did not include directions to staff regarding the application of bed rails for the resident. On two specified dates in January 2015, resident #010 was observed in bed with two three quarter bed rails in the raised position. Staff interviewed confirmed that they raised the bed rails to ensure the resident's safety when the resident was in bed. Registered staff confirmed that the resident's plan of care did not include the use of bed rails as a PASD or restraint for resident #010. [s. 33. (3)]

2. The licensee failed to ensure that the use of a Personal Assistance Services Device (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 were satisfied:

1. Alternatives to the use of a PASD had been considered, and tried where appropriate.
2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASD's that would be effective to assist the resident with the routine activity of living.
3. The use of the 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.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A) On specified dates in January 2015 and February 2015, resident #025 was observed sitting in their wheelchair with a specific PASD. The resident was unable to release the PASD from the wheelchair. PSW and RPN staff confirmed that the resident used this PASD during meal and snack times and that the PASD had a restraining effect. No documented assessment of the resident for the use of the PASD or for alternatives was found during a review of the resident's plan of care. In addition, no documented approval and no consent for the use of the PASD were found in the resident's plan of care. During interview with LTC Inspector, an RPN and physiotherapist confirmed that the resident had not been assessed for the appropriate use of the PASD and that it had a restraining effect. They also confirmed that the PASD was not approved or documented, and consent had not been given for the use of the PASD for resident #025.

B) Resident #012's bed was observed with two quarter bed raised during the course of this inspection. Registered staff and PSW's stated the bed rails were raised when in bed

and were used for turning and repositioning. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rail, nor any documented consent or approvals for their use. The registered staff confirmed that the resident's bed rails were not assessed to determine if they were being used as a PASD or a restraint nor did they have documented consent or approval for the bed rails in place.(581) [s. 33. (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 the use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living is included in a resident's plan of care only if the following are satisfied, alternatives to the use of a PASD are considered and tried where appropriate, the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, and the use of the PASD has been consented to by the resident or SDM, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) During an identified day in February 2015, nine out of fifteen residents who were scheduled to be bathed or showered did not receive their scheduled bath. Registered and PSW staff confirmed that the day shift in the home was short two PSW staff on and identified day in February 2015. Interview with two residents confirmed they did not get their scheduled bath on a specific day in February and were not offered a make up bath due to short staffing. Review of the PSW flow sheets did not include any indication that nine of fourteen residents received their scheduled baths. Interviews with three direct care staff indicated that, due to short staffing residents did not receive any assistance to bathe as scheduled on an identified day in February, 2015. Front line staff confirmed with the LTC Inspector that residents who did not receive baths on an identified day in February 2015, did not did receive a make up bath and that only one bath was received by these residents during a specific week in February 2015.

B) Resident #023 was observed to be unclean and ungroomed on an identified date in January 2015. Review of the resident's plan of care indicated they were to receive a shower two times a week. Review of flow sheets revealed that in the week of February 1 to 7, 2015, the resident received one shower. A PSW reported that the home's expectation was that all residents received a bath or shower twice a week, and that incomplete documentation indicated that care was not provided. This was confirmed by Registered nursing staff and the DOC. (585) [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirement, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that safe transferring and positioning techniques were used when assisting resident #026 to bed.

Resident #026's plan of care stated they were to be transferred and assisted in bed mobility by two staff always and the resident was at high risk of falls related to physical limitations, poor balance, and cognitive loss.

On an identified day in February 2015, resident #026 fell out of bed, after a PSW attempted to transfer the resident down in bed independently. Interviews with the PSW and RN on duty during the incident confirmed the resident received assistance from the two staff with toileting. After the resident was transferred back to a sitting position in bed, the RN left and the PSW was alone with the resident. The resident became unsteady and the PSW attempted to transfer the resident down to bed. The PSW reported that when they attempted to assist the resident, they unintentionally put their arm behind the resident's neck instead of shoulders, causing the resident distress. The resident scratched the PSW and attempted to hit them. The resident lost balance and fell out of the bed, hitting their head and knee, resulting in bruising. They were later sent to hospital as a result of the fall. The PSW reported the resident always required two staff when transferring. The RN confirmed they left to attend to another resident before resident #026 was completely transferred back to bed, and the resident should have received assistance from two staff. [s. 36.]

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the home.

According to the resident's health record, resident #016 sustained a skin tear to their wrist on an identified day in December 2014. In addition, on an identified day in January, 2015, resident #016 fell, at which time they sustained a skin tear to their arm. Review of the resident's health record indicated that the resident had not been assessed by a registered dietitian regarding either skin tear. During an interview and review of the dietary referral that was made on January 2015, the treatment RPN confirmed that the dietitian had not assessed resident #016 as of February 10, 2015, in relation to a skin tear sustained on an identified day in January 2015.

During interview with the dietitian on February 12, 2015, the dietitian confirmed that the skin assessments for resident #016 had not been completed in relation to skin tears that occurred on December 2014 and January 2015. The dietitian also confirmed that the resident had weight loss greater than ten percent in the past six months as of January 2015 and that the resident's dietary treatment had not changed since September 2014. The dietitian stated that the resident's plan of care should have been updated in light of the resident's altered skin integrity, their weight loss and that treatment had not changed since September 2014. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the home, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the continence program included an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff.

The home's 2014, satisfaction survey evaluation questions were reviewed and did not include an evaluation of continence care products in consultation with residents or substitute decision makers. The DOC confirmed the home did not complete an evaluation of resident satisfaction of continence care products in 2014. [s. 51. (1) 5.]

2. The licensee failed to ensure that the resident who was incontinent received an assessment that included causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #023 was admitted to the home in early 2013. The resident's MDS coding documentation revealed that their bladder and bowel continence levels changed several times from February 2013 up to December 2014.

In February 2013, the resident's bladder continence was coded as incontinent. In May 2013, the resident's continence changed to be frequently incontinent, and remained unchanged until the most recent MDS assessment in December 2014.

In February 2013, the resident's bowel continence was coded as incontinent. In May 2013, the resident was coded as frequently incontinent. In August and December 2013 and March 2014, the resident was coded as usually incontinent of bowel. In June and September 2014, the resident's coding increased to occasionally incontinent of bowel. In December 2014, the resident's coding increased to frequently incontinent of bowel.

Review of the clinical records indicated that there was no continence assessment upon admission and when the resident's bladder and bowel continence levels changed to identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions. Registered staff confirmed they did not complete continence assessments upon admission or when the residents were identified as having a change in continence. (585) [s. 51.(2)(a)]

3. The licensee failed to ensure resident #015 was provided with a range of continence care products that promoted continued independence wherever possible.

Resident #015 used pull-up style continence products supplied by their family. Interviews with multiple nursing staff confirmed pull-up style was better suited for the resident, as it promoted their independence in toileting. Multiple nursing staff (registered and unregulated) reported that pull up style continent care products were only available and used in the home when provided by the resident/representative. This was confirmed by the DOC. [s. 51.(2)(h)(iv)]

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 continence program includes an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff, that the residents who are incontinent receive an assessment, that continence care products were readily accessible to residents and staff at all times and that the resident is provided with a range of continence care products that promoted continued independence wherever possible, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with weight change of ten percent of body weight or more over six months, were assessed using an interdisciplinary approach and that actions were taken and outcomes evaluated.

Review of dietary progress note written by the Food Services Manager(FSM) on an identified day in January 2015, indicated that resident #016 had a decreased appetite, was refusing meals, had a ten percent decrease in body weight in the past six months and was below a healthy weight range in relation to body mass index. The RAP completed on January 2015, confirmed these observations. Interview with the FSM indicated that a referral was made to the dietitian on an identified day in January 2015, when the resident's nutritional risk was changed to high (scored as 10) from medium risk (scored as five).

The document the home referred to as resident #016's "care plan" completed January 2015, indicated a moderate nutritional risk. The electronic medication record indicated that they were receiving dietary interventions that began on September 2014 and had not been updated as of February 2015. The dietitian confirmed the plan of care had not changed to address the increase in nutritional risk. Review of the dietary referral and progress notes indicated that a dietary assessment of the resident, implementation of actions or evaluation in terms of the management of weight loss had not been completed in response to the resident's increase in nutritional risk. This was confirmed by the FSM. [s. 69. 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with weight change of ten percent of body weight or more over six months, are assessed using an interdisciplinary approach and that actions are taken and outcomes evaluated, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provided direct care to residents received training annually in accordance with O. Reg 79/10, s. 221 (1) 2 in the area of skin and wound care, O. Reg 79/10, s. 221 (1) 3 in the area of continence care and bowel management.

A) Information provided by the home confirmed that none of the direct care staff who provided assistance to the residents received training in skin and wound care in 2014.
B) Information provided by the home confirmed that none of the direct care staff who provided assistance to the residents received training in continence care and bowel management in 2014.
This was confirmed by the DOC. [s. 76. (7) 6.]

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 all staff who provided direct care to residents receive training annually in the area of skin and wound care and in the area of continence care and bowel management, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for the cleaning of the home in resident bedrooms and common areas.

During the course of the RQI, observations were made through the home identifying unclean surfaces on resident and common area floors, in and behind doors, baseboards, and lights. Two housekeeping staff reported there was no routine schedule in the home for cleaning of baseboards, vents, and lights. Front line staff also reported that resident rooms only received a deep clean upon transfer or discharge from their room. Interview with the Environmental Services Supervisor and maintenance staff confirmed that the home did not have procedures implemented in the home for regular deep cleaning of the identified areas above. [s. 87. (2) (a)]

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 procedures are developed and implemented for the cleaning of the home in resident bedrooms and common areas, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD under section 33 of the Act was applied by staff in accordance with the manufacturer's instructions.

The home's "Resident Care Quality Indicators" policy for "Physical Restraints" reference number RESI-10-01-01 last reviewed November 2012, included but was not limited to directing staff to ensure that the restraint was appropriately applied. The policy included the manufacturer's "Pelvic Support User's Guide" and the vendor's "Belt Application for Proper Positioning" which directed staff to apply the lap belt "not too loose to allow client to slide under belt...just enough space for two fingers to fit between the belt and pelvic crest". The home's policy for "Consent for Restraint Use" reference number RESI-10-01-03 last reviewed November 2012, indicated that death from strangulation was a risk associated with physical restraints.

A) On an identified date in January 2015, at approximately 1500 hours, resident #30 was observed sitting in a wheelchair with a lap belt in place that was noted to be applied with a space between the lap belt and torso that was greater than five finger widths. The resident stated they liked the lap belt in place as it helped them feel safe. They demonstrated to the LTC inspector that they were able to apply and undo the lap belt. The resident stated to the LTC Inspector that they were concerned that the lap belt was too loose.

A RPN was observed to inspect the loose lap belt, confirmed that it was loose, was unable to adjust it to a safe position, and returned to a different task without taking steps to correct the unsafe lap belt. On January 29, 2015, at approximately 1510 hours the LTC Inspector notified the Administrator of the unsafe lap belt for resident #30. The Administrator confirmed that the lap belt was loose and adjusted it to a safe position.

B) On identified dates in January and February 2015, resident #012 was observed sitting in a wheelchair with their front fastening lap belt applied. It was noted on each day there was a four to five finger width space between the resident's torso and the lap belt. The resident was able to apply and undo their lap belt independently. Registered staff and PSW's confirmed that the seat belt was too loose, not properly applied and that the resident did not have their front fastening lap belt applied according to manufacturer's instructions. (581) [s. 111. (2) (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 PASD under section 33 of the Act are applied by staff in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared.
O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure there was a written record of each annual evaluation for minimizing of restraining which included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The DOC confirmed the home did not complete an annual evaluation for minimizing of restraining in 2014. [s. 113. (e)]

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 there was a written record of each annual evaluation for minimizing of restraining which included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Review of the home's Professional Advisory Committee meeting minutes for 2014, indicated that on October 30, 2014, the home had evaluated the effectiveness of the medication management system in the home but did not make recommendations to improve the system. During interview, the DOC confirmed that the home had not conducted an evaluation of the home's medication management system or made recommendations to improve the system on a quarterly basis in 2014. [s. 115. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

A) On an identified date in February, 2015, during a medication pass at 1030 hours on third floor, a medication cart was found unlocked and unattended by registered nursing staff. Two residents and one PSW were noted to be present by the cart. The RPN conducting the medication pass confirmed the cart was unlocked and should be locked at all times when not in use.

B) On an identified date in January 2015, topical medications were found at the bedsides of residents #030 and #032. A RPN and PSW staff confirmed that the medications should not have been stored in the residents' rooms but should have been secured in the treatment cart or PSW treatment box. Staff confirmed that medications had not been stored so that they were secured and locked.

Throughout the course of this inspection, carts containing supplies used by PSW's were observed in the hallways, unattended by PSW staff and tub room doors were observed opened, with PSW carts being stored inside of the tub room. Inspection of the carts by LTC Inspector revealed that residents' topical medications were located in unlocked containers on these carts while stored in the hallway or in the unlocked tub rooms. Interview with RPN confirmed that the tub room door should be locked when not in use. PSW's confirmed that resident topical medications located in unlocked PSW carts either in the hallway or in the unlocked tub rooms were not stored and kept locked at all times, when not in use. The DOC confirmed that the medications should be stored so that they were secured and locked when not in use. (526) [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

On February 4, 5, 6, 2015, there was no registered nurse on duty on the day shift and this was confirmed by the Administrator. [s. 8. (3)]

WN #19: 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 failed to ensure that where the Act or this Regulation required the licensee to have or put in place any policy, procedure, that the policy, procedure was complied with.

Registered staff did not comply with the directions contained in the home's "Falls Prevention and Management Program" identified as RESI-10-02-01, version April 2013.

The policy directed that a Morse Fall Risk Assessment was to be completed when a fall RAP was triggered in the MDS assessment and at the time of significant change in resident status.

Resident #040 had the Morse Fall Risk Assessment completed on an identified day in January and December 2014, and the resident had eleven falls during this period with the last fall on an identified day in November 2014, which resulted in a significant change and triggered a falls Resident Assessment Protocol (RAP). DOC confirmed that the home's policy was not followed when the Morse Fall Risk Assessment was not completed quarterly and at the time of a significant change. [s. 8. (1) (a),s. 8. (1) (b)]

WN #20: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's plan of care was based on an interdisciplinary assessment of sleep patterns and preferences.

Review of resident #011's plan of care revealed that there was no interdisciplinary assessment or plan regarding the resident's sleep and rest patterns and preferences.

i) During interview with the LTC Inspector, resident #011 complained that they did not like to get up early in the morning. On a specified date in February 2015, at approximately 0645 hours, PSW staff was observed providing morning care to resident #011. Interview with the PSW indicated that the resident was frequently awake singing during the night and was awake early in the morning. According to interviews with co-residents and the PSW staff, resident #011's wakefulness disturbed co-residents' sleep. The PSW described interventions they had attempted to settle resident #011 but confirmed that the plan of care did not include direction regarding the resident's sleep patterns and preferences.

ii) During interview with the LTC Inspector, resident #011 indicated that they didn't like going to bed too early and that they preferred to attend evening recreation activities offered in the home. PSW staff interviewed stated that they assisted the resident to bed shortly after dinner, at about 1830 hours unless the resident wanted to go to a recreation program. They were not aware that the resident did not want to go to bed too early. RPN staff and the RAI Coordinator confirmed that resident #011's plan of care did not include a multidisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all planned menu snack pass beverages and snacks were offered to residents.

A) During Stage 1 of the RQI, resident #015, #021, and #026 reported they were not always provided with a snack and/or beverage between meals.

B) On February 3, 2015, the afternoon snack pass was observed on third floor. Drinks available on the snack cart included tea, coffee, water, apple juice, and lemonade, and the snack was a date cookie. The PSW who was distributing snacks and drinks was observed not offering all available beverages or the available snack.

i) Resident #015 was offered a beverage, and was not offered a cookie.
ii) Resident #050 was offered a coffee, no other drink choice, and was not offered a cookie.
iii) Resident #051 was only offered a coffee, no other drink choice, and was not offered a cookie.
iv) Resident #052 was only offered a drink, and was not offered a cookie.
v) Resident #053 was only offered coffee, and no other drink choice.

The PSW reported drinks and snacks were to be offered to all residents. The FSM stated that while residents may prefer certain beverages, all beverage choices and snacks should be offered to all residents, unless indicated otherwise in their plan of care. The listed residents plans of care did not include exclusions to the regulatory requirements to offer planned menu items during afternoon snack pass. [s. 71. (4)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure foods and fluids were served using methods to prevent contamination.

On February 3, 2015, in the afternoon on the third floor, a PSW was distributing snacks and beverages. During the course of the snack pass, the PSW was observed to lick their finger, pick up litter off the floor, touch a soiled linen cart, enter in and out of rooms identified as being on contact precaution and used their hands to serve cookies without tongs, without performing hand hygiene between tasks. The PSW also left the snack cart unattended in a resident's room to return to the dining room to retrieve more cups. The PSW confirmed the cart was not to be left unattended. The RPN confirmed hand hygiene should be performed when entering and exiting rooms on contact precaution. [s. 72. (3) (b)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

A review of the Residents' Council Meeting Minutes from January to June 2014, indicated that a review of the meal and snack times was not approved by the Residents' Council. Interview with the Program Manager and an Executive Member confirmed meal and snack times were not reviewed in 2014. [s. 73. (1) 2.]

WN #24: 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 did not seek the advice of the Residents' Council in the development and carrying out of the satisfaction survey, and in acting on its results.

A Resident Council Executive Member stated the Council had not participated in the development and carrying out of the satisfaction survey. Interviews with the Council Assistant and a review of Resident Council Meeting Minutes from the past eight months, confirmed that the Councils advice was not sought regarding the satisfaction survey specifically related to its development, implementation and in acting on the results. [s. 85. (3)]

Issued on this 14th day of April, 2015

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

D. Berkovich

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANNE BARSEVICH (581), LEAH CURLE (585), LISA VINK (168), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2015_337581_0003
Log No. / Registre no:	H-001934-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 23, 2015
Licensee / Titulaire de permis :	BLACKADAR CONTINUING CARE CENTRE INC. 101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7
LTC Home / Foyer de SLD :	BLACKADAR CONTINUING CARE CENTRE 101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jarrod McIntosh

To BLACKADAR CONTINUING CARE CENTRE INC., 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)

Linked to Existing Order / Lien vers ordre existant: 2014_191107_0004, CO #003;

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 :

Where bed rails are used, the licensee shall do the following:

1. Evaluate each bed system to identify risk of entrapment and document this evaluation;
2. Take steps to prevent risk of entrapment by performing the necessary modifications according to the bed system evaluation and document steps taken;
3. Re-evaluate bed systems once they have been altered or modified and document this evaluation;
4. Assess residents in relation to his or her bed system and document this assessment for each resident, where bed rails are used.

Grounds / Motifs :

1. A previous order had been served for O. Reg79/10, s. 15 (1) on February 20, 2014 during inspection 2014_191107_0004.

2. The licensee 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) A review of resident #012's written plan of care indicated they required the use of two quarter bed rails in the raised position for bed mobility and repositioning when in bed. Interviews with the RPN and PSW's confirmed their bed rails were raised when in bed. Review of the resident's written plan of care did not include an assessment of the bed rails being used. The registered staff confirmed that the home did not have a formalized assessment for the use of bed rails in place.

B) According to the home's maintenance files, all bed systems in the home were inspected for entrapment risk to residents on February 3, 2014; however, 34 of 79 bed systems failed in at least one zone of entrapment. According to the Administrator, steps were taken to address the failed zones of entrapment; however, a facility entrapment inspection sheet dated April 9 and 10, 2014, indicated that 14 of the 34 failed beds had been reassessed and passed the inspection. The Administrator could not confirm that the remaining 20 beds were free of entrapment risk to residents.

On February 10, 2015, the following beds that had failed zones of entrapment on February 3, 2014 and were not reassessed on April 9 and 10, 2014, were observed to have residents laying in them with bed rails in the raised position:
i) Bed #42 failed entrapment risk in zone two. A resident was observed laying in bed #42 with two half bed rails in the raised position;
ii) Bed #74 failed entrapment risk in zones two, three and four. A resident was observed laying in bed #74 with two quarter bed rails in the raised position; and
iii) Bed #50 failed entrapment risk in zone two. A resident was observed laying in bed #50 with two three quarter bed rails in the raised position.

The Administrator could not confirm that these beds had been assessed and evaluated to minimize risk to these residents. (526)

C) On two identified dates in January 2015, resident #010 was observed laying in bed with two three quarter bed rails in the raised position. The resident had a diagnosis of uncontrolled movements and limited mobility. Review of the resident's plan of care indicated that the resident had been using bed rails for bed mobility for at least the past year; however, this review also revealed that the resident had not been assessed in their bed system to minimize the risk to the resident. Registered staff and the RPN who assisted the DOC confirmed

that resident #010 had not been assessed in their bed system to minimize the risk to the resident (526)

D) On specified dates in January and February 2015, resident #025 was observed laying in bed with two three quarter bed rails in the raised position. Review of the resident plan of care indicated that the resident had been using bed rails for bed mobility for at least the past year; however, this review also revealed that the resident had not been assessed in their bed system to minimize the risk to the resident. Registered staff and the RPN who assisted the DOC confirmed that resident #025 had not been assessed in their bed system to minimize the risk to the resident. (526)

(581)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall do the following with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act;

1. All direct care staff shall be retrained at least annually regarding the application of lap belts in accordance with manufacturer's instructions.
2. Where a lap belt is applied for the purposes of restraining a resident, including residents #010 and #031, staff will apply the lap belt in accordance with manufacturer's instructions.
3. Where a lap belt is applied for the purposes of restraining a resident, including residents #010 and #031, the resident will be monitored hourly regarding the application of the lap belt in accordance with manufacturer's instruction.
4. If the lap belt is found not to be applied in accordance with manufacturer's instructions, staff will adjust the lap belt so that it conforms with the manufacturer's instructions.
5. The hourly monitoring of the resident will be documented in the resident's health record.

Grounds / Motifs :

1. This non compliance was issued as a VPC on January 10, 2014.

2. The licensee failed to ensure that a physical device was applied in accordance with the manufacturer's instructions.

The home's "Resident Care Quality Indicators" policy for "Physical Restraints" reference number RESI-10-01-01 last reviewed November 2012, included but was not limited to directing staff to ensure that the restraint was appropriately applied. The policy included the manufacturer's "Pelvic Support User's Guide" and the vendor's "Belt Application for Proper Positioning" which directed staff to apply the lap belt "not too loose to allow client to slide under belt...just enough space for two fingers to fit between the belt and pelvic crest". The home's policy for "Consent for Restraint Use" reference number RESI-10-01-03 last reviewed November 2012, indicated that death from strangulation was a risk associated with physical restraints.

A) Staff confirmed that resident #010 had a diagnosis of uncontrolled movements and limited mobility. The resident's plan of care and staff interviews confirmed that the resident had a lap belt applied while sitting in their wheelchair to prevent the resident from falling in the event that they had uncontrolled movements.

On an identified date in January 2015, at approximately 1000 hours resident #010 was observed sitting in their wheelchair with a lap belt applied 20 centimeters from the resident's torso. A registered practical nurse (RPN) confirmed that the lap belt was loose but could not state the manufacturer's recommended tightness of the lap belt application. The RPN attempted to tighten the lap belt but could not and stated that the vendor would need to make the adjustment. The RRN left the resident unattended with the lap belt loose across the resident's torso.

At 1030 hours, the resident's lap belt continued to be loose and the resident was unattended by staff.

At 1040 hours the LTC Inspector informed the Administrator that the resident's lap belt was loose and he confirmed that the lap belt posed a risk to the resident given their health condition and history.

At 1100 hours, approximately 20 minutes after the Administrator was informed of the risk to resident #010, the resident was observed in the dining room sitting in their wheelchair with the loosened lap belt, positioned with their back to the door while closely surrounded by several residents. An RPN confirmed that it would be difficult to attend to the resident if they began to have a seizure in their

wheelchair and confirmed that the resident's lap belt was loose.

At 1115 hours, the Administrator stated that the vendor had been contacted and would be in the home to adjust resident #010's lap belt some time that day. The Administrator confirmed that the resident's safety had to be addressed immediately.

At approximately 1130 hours, resident #010 was observed sitting in an alternate wheelchair with a lap belt that was applied with two finger widths between the belt and the resident's torso.

During interview with the LTC Inspector, the RAI Coordinator confirmed that resident #010's lap belt was loose on an identified date in January 2015 and stated that it would be difficult to tell how long the belt had been applied unsafely. They confirmed that staff were supposed to be checking the resident's restraint hourly for safety and that the application of the lap belt should be part of this safety check.

B) On an identified date in January 2015, at approximately 1010 hours, resident #031 was observed sitting in their wheelchair with lap belt applied so that it was positioned at least four finger widths between the lap belt and their torso. A RPN inspected the lap belt and stated that it was positioned correctly.

At 1035 hours, the resident's lap belt continued to be loose and the resident was unattended by staff. The RPN stated that they had not repositioned the lap belt.

At 1040 hours the LTC Inspector informed the Administrator that the resident's lap belt was loose and he confirmed that the lap belt posed a risk of strangulation to the resident.

At 1100 hours, approximately 20 minutes after the Administrator was informed of the risk to resident #031, the resident was observed sitting in the hallway with the lap belt positioned two finger widths between the belt and the resident's torso. The Administrator stated that the Director of Care (DOC) came and adjusted the resident's lap belt. (526)

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

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee shall complete the following;

1. Evaluate and update at least annually the interdisciplinary programs;
i) Falls Prevention and Management Program
ii) Skin and Wound Care Program
iii) Continence Care and Bowel Management Program

2. Provide completed and documented written record relating to each evaluation that includes;
i) the date of the evaluation,
ii) the names of the persons who participated in the evaluation
iii) a summary of the changes made
iv) that date those changes were implemented.

Grounds / Motifs :

1. The licensee failed to ensure that, with in respect of each of the interdisciplinary programs required under section 48 of this Regulation, each program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Review of the home's program evaluation files revealed that the home had not evaluated the following programs:
i) Falls prevention and management
ii) Skin and wound care
iii) Continence care and bowel management

The DOC confirmed that these programs had not been evaluated in 2014. (526)

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

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.

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

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 23rd day of March, 2015

Signature of Inspector / Signature de l'inspecteur : D. Barsevich

Name of Inspector / Nom de l'inspecteur : Dianne Barsevich

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