Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 7, 2015	2015_355588_0026	023264-15 025356-15 025721-15	Complaint

Licensee/Titulaire de permis

MACGOWAN NURSING HOMES LTD
719 Josephine Street P.O. Box 1060 WINGHAM ON N0G 2W0

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

BRAEMAR RETIREMENT CENTRE
719 Josephine Street North, R.R. #1 P.O. Box 1060 WINGHAM ON N0G 2W0

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

CHRISTINE MCCARTHY (588), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 2015.

This inspection was conducted concurrently with Ministry of Health and Long Term Care Resident Quality Inspection Log # 024280-15 and Complaint Inspection Log # 018714-15, IL-39606-LO.

During the course of the inspection, the inspector(s) spoke with one resident, one Physician, two Registered Practical Nurses, one Registered Nurse, the Administrator, one Housekeeping Aide, and one Ward Clerk.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Personal Support Services
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the residents were 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. Steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

This finding of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) under LTCHA, 2007, under O.Reg. 79/10, s. 15(1) on August 29, 2014, Inspection # 2014_259520_0026.

Record review of the Facility Entrapment Inspection Sheet dated May 28, 2014 revealed 70 out of 73 beds failed at least one zone of entrapment.

Record review of the Maintenance/Bed Audit May 4, 2015 revealed actions were not taken to correct the deficiencies as indicated in the Facility Entrapment Inspection dated May 28, 2014.

Record review of assessments in Point Click Care and in resident paper charts revealed no resident assessments were found related to bed rail use.

In an interview with Inspector #213 on September 22, 2015, the Administrator and Maintenance Staff confirmed that the Facility Entrapment Inspection completed May 28, 2014 was no longer valid as they have since changed mattresses, beds, moved beds, and purchased some new beds and mattresses. They also shared that they have not taken actions to address the deficiencies noted in the inspection dated May 28, 2014 to minimize risk to the residents.

In an interview with Inspector #213 on September 24, 2015, the Administrator confirmed that they have not completed resident assessments related to bed rail use. [s. 15. (1)]

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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan including 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.

In an interview with Inspector #213 on September 22, 2015, the Administrator confirmed that there had not been an annual evaluation of the staffing plan which included the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 31. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written record of each annual evaluation of the staffing plan including 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 #3: 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 has failed to ensure that the residents were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

This finding of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) under LTCHA, 2007, under O.Reg. 79/10, s.33(1) on August 23, 2013, Inspection #2013_183135_0050.

Three anonymous complaints were received by the Inspectors related to residents missing baths due to staffing shortages.

Record review of Point of Care bathing documentation by Inspector #610 revealed that out of 12 residents' documentation reviewed, four residents had not received at least two baths during a seven day period.

Resident #057 received a bath on September 6, 14, 16, 2015. Resident #057 did not receive a bath on three specific dates. Review of the bath schedule revealed that they were scheduled to have baths on specified days twice per week.

Resident #058 received a bath on September 14, 21, 23, and 24, 2015. Resident #058 did not receive a bath on a specific date. Review of the bath schedule revealed that they were scheduled to have baths on specified days twice per week.

Resident #059 received a bath on September 12, 22, and 23, 2015. Resident #059 did not receive a bath on three specific dates. Further review of Point Click Care documentation did not show that resident #059 had missed three consecutive baths. Review of the bath schedule revealed that they were scheduled to have baths on specified days twice per week.

Resident #045 had received a bath on September 7, and 14, 2015. Resident #045 did not receive a bath on a specific date. Review of the bath schedule revealed that they were scheduled to have baths on specified days twice per week.

Interview with a registered staff member and the Ward Clerk revealed that when the home was short staffed, baths were canceled. The Ward Clerk completed bath audits

weekly and noted that the residents who missed baths were to have "catch up baths" completed. Catch up baths were not always completed during the same week of the missed scheduled bath. [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 the residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 7th day of October, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHRISTINE MCCARTHY (588), RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2015_355588_0026
Log No. / Registre no:	023264-15 025356-15 025721-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 7, 2015
Licensee / Titulaire de permis :	MACGOWAN NURSING HOMES LTD 719 Josephine Street, P.O. Box 1060, WINGHAM, ON, N0G-2W0
LTC Home / Foyer de SLD :	BRAEMAR RETIREMENT CENTRE 719 Josephine Street North, R.R. #1, P.O. Box 1060, WINGHAM, ON, N0G-2W0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ARCHIE MACGOWAN

To MACGOWAN NURSING HOMES LTD, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan to ensure, where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices to minimize risk to the resident. Specifically, the licensee shall ensure that all residents who use bed rails are assessed for bed rail use and all bed systems are evaluated according to the Health Canada Guidance Document for Adult Hospital Beds. The plan must include what immediate and long-term actions will be undertaken to correct the identified deficiencies, as well as identify who will be responsible to correct the deficiencies and the dates for completion.

Please submit the plan, in writing, to Christine McCarthy, Long-Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, Ontario, N6A 5R2, by email, at Christine.M.McCarthy@ontario.ca by October 30, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the residents were 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. Steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

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In an interview with Inspector #213 on September 24, 2015, the Administrator confirmed that they have not completed resident assessments related to bed rail use. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 29, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7th day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Christine McCarthy

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