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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 21, 27, 2013	2013_190159_0032	H-000742-13	Other

Licensee/Titulaire de permis

THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA
155 PANIN ROAD, BURLINGTON, ON, L7P-5A6

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

CAMA WOODLANDS NURSING HOME
159 PANIN ROAD, BURLINGTON, ON, L7P-5A6

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

ASHA SEHGAL (159), BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 12, 15, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Food Service Supervisor, Environmental Services Supervisor, Activation Manager, registered staff, Registered Dietitian, Personal Support Workers (PSWs), dietary staff and residents.

During the course of the inspection, the inspector(s) toured the home, tested the resident-staff communication and response system, tested the ambient air temperatures, observed resident beds, observed residents and the equipment used by residents, reviewed clinical records, Resident Council Committee meeting minutes, the home's policies and procedures, observed lunch meal service and reviewed menus.

The following Inspection Protocols were used during this inspection:
Dining Observation

Family Council

Residents' Council

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 did not ensure that the staff applied a physical device for the purpose of restraining a resident in accordance with the manufacturer's instructions.

Resident #00004, resident #00005, resident #00008, and resident #00009 were observed November, 2013 on a specified date to be wearing front closing clip style seat belt which was loosely applied around the abdomen. The belts were applied approximately 10-15 inches from the abdomen. As a result the seat belt had no restraining effect and posed a significant risk for residents sliding down in the wheelchair. The manufacturer's instructions stated the seat belt was to applied snug to the body. A Personal Support Worker(PSW)who was present in the activity room and was interviewed was unable to identify that the belt was applied loosely nor were they able to provide information on how tight or loose the belt should be. The PSW tightened the residents' belts on request of the inspector. The Director of Care confirmed that the restraint orientation and education was provided to all staff when employed and then every year thereafter. [s. 110. (1) 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to residents, specifically residents #00001, #00002, #00003, #00005, #00007 and #00010.

The diet notes and the plans of care for resident #00001 and resident #000010 identified to provide nutritional supplement at meals 3x a day. Staff interviewed confirmed that the dietary staff dispenses supplement and mixes in the soup, cereal or milk. On November 12, 2013 the supplement was not provided to resident #00001 and resident #00010 when the lunch meal was observed.

The plan and the current diet list for resident #00003 indicated to provide ½ portions of main course at lunch and supper and 125 ml extra water at meals. On November 12, 2013 at lunch meal the resident was served a full serving of egg salad sandwich and 125 ml of water, but extra water was not served.

The diet list and the plans of care for resident #00007 and resident #00002 stated to provide 250 ml extra water with meals to meet daily fluid requirements. On November 12, 2013 residents were served only 125 ml of water, extra water was not served with the lunch meal.

Resident #00002 had an order for a modified therapeutic diet. The resident did not receive a modified therapeutic diet as specified on the diet list and the plan of care. On November 12, 2013 the therapeutic menu posted indicated ½ serving of egg salad sandwich for a modified diet, however, the resident was served a regular serving of entrée, a whole egg salad sandwich.[s. 6.(7)]

2. The licensee did not ensure that the provision of the care in the plan of care is documented.
The licensee did not ensure that when residents were receiving nutritional supplement that there was documentation and monitoring of supplement intake. The plans of care for resident #00001 and resident #00010 identified to provide nutritional supplement 3 x a day at meals. However, no supportive documentation was found that the supplement was provided to the residents and the supplement was consumed or refused by the residents. The Food Services Supervisor confirmed that the dietary staff dispenses the supplement but there was no system in place to document and monitor the intake of the protein powder supplement. [s. 6. (9) 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 care set out in the plan of care is provided all residents as specified in the plan.[6(7)]and ensuring that the provision of care set out in the plan of care including diets and the nutritional supplements are documented and monitored[(6)9], to be implemented voluntarily.

WN #3: 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 did not ensure that where the Act or the Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that those plans, protocols, procedures, strategy or systems were complied with, in relation to the following: [8 (1)(b)]
Staff in the home did not comply with the following policies and procedures related to the diet orders.

The home's Diet Order policy identified as #05-02-02 dated September 10, 2010 directed staff that all diets (therapeutic and consistency) and nutritional supplements will be ordered by a physician or Registered Dietitian(per directives). The order will be reviewed every three months. The home's procedure stated that the Physician/Dietitian writes orders using assessment information. The Registered Nurse, Food Services Supervisor, Director of Care and the clinical documentation confirmed that these directions were not complied with when it was noted that there was not a physician or dietitian's order for the nutritional supplement when resident #00001 and resident #000010 were receiving nutritional supplement 3x a day with meals. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that where the Act or the Regulations require licensee to have,institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that those plans, policies, protocols, procedures, strategies or systems are complied with, to be implemented voluntarily.

WN #4: 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 not taken any steps to prevent resident entrapment where bed rails are used.

The licensee hired an external company to complete a bed safety audit which was completed on January 7, 2013. The auditor identified 33 beds that failed entrapment zone 4, which relates to excessive compression or space at the end of the bed rail. The entrapment risk is greatest when one or both bed rails are raised and remain raised while the resident is in bed. Entrapment failure can occur for various reasons, but usually relate to the shape of the rail(rounded), an older foam mattress, an air mattress without reinforced edging or missing mattress keepers. Out of the 33 beds that failed, 11 were confirmed by a registered nurse to be in use by residents who use both rails when in bed. A record review revealed that each of these residents were required to have both rails raised when in bed for safety related to fall prevention or for mobility. A tour of the home revealed that these residents each had 3/4 length chrome rails attached to their beds and no bed accessories to mitigate entrapment zone risks such as gap fillers or bed rail pads. Registered staff could not provide any evidence that the 11 residents and others who use at least one rail when in bed have been assessed in any way to reduce or mitigate the zone 4 entrapment.

The Director of Care, who was not available during the inspection, was contacted on November 19, 2013. The Director of Care reported that measures to mitigate zone 4 risk have already begun and that all residents will be receiving new beds free of entrapment zones when they move to a new building in February 2014. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee takes steps to prevent resident entrapment where bed rails are used, to be implemented voluntarily.

WN #5: 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 did not ensure that the planned menu items were served to residents. The portion sizes listed on the planned menu were not offered to residents. Example: The therapeutic cycle menu indicated 6 fluid oz serving of milk was to be served at meals. However, during the lunch meal on November 12, 2013 residents received 4 fluid oz serving milk, resulting in insufficient serving of fluids. [s. 71. (4)]

Issued on this 2nd day of December, 2013

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

Abe Sehgal B. Sosnik

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ASHA SEHGAL (159), BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2013_190159_0032
Log No. / Registre no:	H-000742-13
Type of Inspection / Genre d'inspection:	Other
Report Date(s) / Date(s) du Rapport :	Nov 21, 27, 2013
Licensee / Titulaire de permis :	THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA 155 PANIN ROAD, BURLINGTON, ON, L7P-5A6
LTC Home / Foyer de SLD :	CAMA WOODLANDS NURSING HOME 159 PANIN ROAD, BURLINGTON, ON, L7P-5A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ARLENE LAWLOR

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

To THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA, 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. 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 prepare, submit and implement a plan that outlines how the home shall ensure that all the requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act. Specifically;

1. How staff will apply the physical device for the purpose of restraining a resident in accordance with the manufacturer's instructions.

The plan is to be submitted electronically to Long Term Care Homes Inspector Asha.sehgal@ontario.ca by December 16, 2013.

Grounds / Motifs :

1. The above non compliance was issued as VPC on June 19, 2012.

The licensee did not ensure that the staff applied a physical device for the purpose of restraining a resident in accordance with the manufacturer's instructions.

Resident #00004, resident #00005, resident #00008, and resident #00009 were observed November, 2013 on a specified date to be wearing front closing clip style seat belt which was loosely applied around the abdomen. The belts were applied approximately 10-15 inches from the abdomen. As a result the seat belt had no restraining effect and posed a significant risk for residents sliding down in the wheelchair. The manufacturer's instructions stated the seat belt was to applied snug to the body. A Personal Support Worker (PSW) who was present in the activity room and was interviewed was unable to identify that the belt was applied loosely nor were they able to provide information on how tight or loose the belt should be. The PSW tightened the residents' belts on request of the inspector. The Director of Care confirmed that the restraint orientation and education was provided to all staff when employed and then every year thereafter.
(159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 16, 2013

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.

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 27th day of November, 2013

Signature of Inspector / Signature de l'inspecteur : Asha Sehgal

Name of Inspector / Nom de l'inspecteur : ASHA SEHGAL

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