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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Amended Public Copy/Copie modifiée du public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 23, 2018 | 2016_210169_0016 (A1) | 030339-16 | Resident Quality Inspection |

### Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Camilla Care Community
2250 Hurontario Street MISSISSAUGA ON L5B 1M8

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

Amended by BERNADETTE SUSNIK (120) - (A1)

### Amended Inspection Summary/Résumé de l'inspection modifié

**The compliance due date for compliance order (CO) #004 was changed from December 28, 2018, to July 2, 2019.**

**Issued on this 23rd day of November, 2018 (A1)**

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

**Original report signed by the inspector.**

Ontario

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Amended by BERNADETTE SUSNIK (120) - (A1)

### Amended 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): October 20, 21, 25, 26, 27, 28, 31, November 1, 2, 3, 4, 8, 2016**

**The following inspections were completed as part of the Resident Quality Inspection:**

**Complaints:**

**036202-15 related to diabetes management, housekeeping, food quality**

**012954-16 related to care, assistance and infection control**

**015392-16 related to dignity and care planning**

**020384-16 related to pain management**

**027477-16 related to laundry, housekeeping and bathing**

**028245-16 related to bathing and care**

**028247-16 related to housekeeping**

**029975-16 related to pain management**

**024694-16 related to abuse and laundry**

**003115-16 related to abuse and documentation**

**006093-16 related to H-00487-14, palliative care**

**014192-16 related to infection control and housekeeping**

**020267-16 related to continence and maintenance**

**024239-16 relating to staffing and care**

**030106-16 related to medications**

**Critical Incidents:**

**036432-15 related to falls**

Ontario

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**008695-15 related to falls**

**Follow up:**

**020555-16 order S. 15 related to bed rails**

**During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Director of Programs (DOP), Resident Relations Coordinator (RRC), Director of Environmental Services (ESS), Director of Dietary Services (DDS), Registered Dietitian (RD), Office Manager, Personal Support Workers (PSS), Registered Nursing staff, housekeeping staff, dietary staff, Behaviour Support staff (BSO), residents, families and substitute decision makers (SDM).**

**The inspectors observed care provision throughout the home, reviewed clinical records and minutes of meetings, toured the home, observed medication administration and medication storage areas, observed recreation activities, reviewed relevant policies and procedures, observed resident-staff interactions, observed posting of required information and observed general maintenance.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of the original inspection, Non-Compliances were issued.**

- **5 WN(s)**
- **2 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>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 did not ensure that where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Long Term Care Homes Inspection Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final

conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined not to be fully developed in accordance with the Clinical Guidance document identified above. During the inspection, numerous residents were observed in bed with one or more bed rails applied in the guard position. Many other beds, while unoccupied, were observed with bed rails in the guard position and covered by a blanket. According to records provided, 190 residents out of 237 residents were assessed to require one or more bed rails as a personal assistance services device (PASD) while in bed.

For this review seven residents were randomly selected, all of whom were observed to either have one or more bed rails in use or had care plans indicating that they required one or more bed rails as a PASD.

According to the Director of Care (DOC) and Associate Director of Care (ADOC), residents all received an assessment by registered staff and their conclusions were documented on a form titled Restraint/PASD Assessment V2". The form, when reviewed, included information about the residents' ability to use any device (seat belt, bed rail, table top, tilt wheel chair), the purpose of the device (whether a restraint or a PASD), associated risk factors and whether any previous alternatives were trialled before implementing the device. The form and assessment process however was not specifically geared towards a resident's sleeping behaviours and risks associated with bed rail use, if applied. No guidance was provided to assist the assessor in making any decisions when check boxes were ticked off and what safe interventions or bed system modifications were made if the bed rails were considered unsafe.

The home's procedures titled "Bed Rails" dated June 2016 and "Bed Rail Safety Guidelines" dated April 2016 required registered staff to assess residents' need for the use of a bed rail and entrapment risk. However, neither of the procedures identified what form was to be completed to guide the assessor in making a decision about the resident's overall risk when using one or more bed rails. The procedures directed registered staff to document their decisions in the care plan and in the resident's progress notes after considering a list of factors which were

identified in the third paragraph above.

A) The home's clinical assessment process related to bed rails did not include a component related to evaluating the resident's sleep patterns, habits and behaviours while sleeping in bed with or without the application of bed rails. There were no details included in any of the home's procedures as to how the assessment of residents would be conducted. Neither the form or the procedures included information regarding if/how long residents were to be observed, the dates that they were observed and the specific behaviours that were to be monitored during the observation period. The "Restraint/PASD Assessment" form did not include any questions related to sleep patterns or behaviours. Notations or registered staff decisions were not made in any progress note for any of the seven residents reviewed regarding the resident's overall risk for bed system injury or entrapment.

B) The "Restraint/PASD Assessment" form which included a section where the assessor was to select what alternatives were trialled, did not adequately identify what bed rail alternatives were trialled prior to applying the bed rails if they were indicated for a medical symptom or condition. The form included a section titled "Previous Alternatives" and listed five check boxes to choose from; environmental (lighting, mats, safe wandering areas), activities and programs, alterations to nursing care (bed alarm, scheduled toileting, increased supervision), physiological strategies (pain management) and psychosocial programs and therapies. Several of the alternatives listed were not geared towards bed safety in any way. For three residents (002, 003, 005) reviewed, the "Previous Alternatives" section was not completed. For the remaining four residents that had the alternatives section completed, no details were provided as to what was implemented in place of the bed rail before it was applied and whether it was successful or not before deciding that a hard bed rail was the safest choice for the resident. It appeared that the assessor(s) had selected the alternatives to be used in conjunction with bed rails as opposed to selecting the "alternative" as a replacement for one or more bed rails.

C) The questions included on the assessment form did not include several key questions related to history of rail injury, entanglement, suspension or entrapment, history of climbing over the rails and whether rails were used in the past and why. Relevant questions were noted to include resident's medical diagnosis, cognitive status and risk factors such as involuntary or spasmodic body movements, risk of falls, balance, medication use, and injury to self. Once the

assessor checked off the boxes that were relevant to the resident, no further guidance was provided to decide whether the resident was at any risk for entrapment or injury if bed rails were to be applied. Out of the seven residents reviewed, two residents (002, 005) were diagnosed with high risk of falls from bed and seizures and resident 007 was diagnosed with involuntary or spasmodic body movements. Residents 001, 004, 006 and 007 were diagnosed with severe cognitive impairment and required extensive assistance from staff to reposition and turn them while in bed. These risk factors, according to the Clinical Guidance document are considered high risk, especially when a resident has a combination of risk factors. The care plan for four residents required that staff apply two bed rails while in bed and the other three residents required staff to apply one bed rail while in bed. It did not appear that the risk factors identified were taken into consideration before including bed rails in the residents' individualized care plans.

D) The "Restraint/PASD Assessment" form did not specify what interdisciplinary staff members participated in the clinical bed safety assessment of the resident. The assessment form did not have any staff names listed. However, according to the DOC, registered staff members did not assess residents independently, but routinely asked PSWs for their input in providing information about residents' specific needs while in bed to determine if one or more bed rails would be of any benefit. PSWs used a computerized system called "Point of Care" to document whether they assisted a resident with a transfer in and out of bed or repositioning while in bed.

Both the ADOC and DOC who participated in the completion of the assessment forms reported that they felt pressured by certain SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation. [s. 15. (1) (a)]

***Additional Required Actions:***

**CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following:**

**s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,**
**(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).**

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).**

**Findings/Faits saillants :**

1. As part of the organized program of maintenance services under clause 15(1) (c) of the Act, the licensee of a long term care home did not ensure that there were schedules and procedures in place for remedial maintenance.

A) The majority of the aluminum slider-type windows located throughout the home (except on fourth floor and some windows on third floor) were not maintained to ensure that they could provide an adequate seal to keep out drafts. The windows were not tight-fitting when closed due to the complete deterioration of the felt seals that once existed around the perimeter of the frames. The windows rattled in the wind and permitted air drafts to enter the room. No procedures were developed to address the care and maintenance of the windows and no schedules were in place to either repair or replace the windows in the near future.

B) The cabinet doors located in various areas throughout the home such as in

dining rooms and in corridor niches (near the nurse's stations) had worn or rough surfaces. A cabinet door under the hand sink in the fourth floor dining room was rough around the edges as the laminate had peeled. The wood cabinet surfaces under the counter in the first, third and fourth floor corridor niches were worn down to raw wood. A portable cabinet unit in the first floor dining room used to store meal aprons was in poor condition, with the top counter section cracked and split. No schedule was in place to remediate the condition of the cabinets and no procedures had been developed to ensure that they were maintained in good condition.

C) Approximately 40 night tables were noted to be in poor condition in resident rooms on all floors. The night tables, made of particle board with a laminate overlay, had exposed particle board along the top front edge of each night table that was very rough. Other night tables were observed to have had an obvious repair made, using an off white wood filler in areas where the laminate had deteriorated and the top surface re-varnished. The result was unsightly but smooth for cleaning purposes. No confirmation could be provided by the home as to whether new tables would be purchased or if there was a schedule in place to replace them. No procedures had been developed to ensure that the night tables were maintained in good condition.

D) Other maintenance issues identified included roller blinds not in good condition on third floor (could not be used as the mechanism to pull the blind up was missing), the plastic bi-fold closet doors in #322 were torn from the pins that held up the doors, the stools used by staff in the various dining rooms were in poor condition, with cracked or split seat covers, flooring material in washroom #331 in front of the toilet area was worn down to the wood sub layer and the fixed grab bars located in washrooms #326, 423, 431, 433 and the portable grab bars attached to the raised toilet seat in washroom #328 were rusty. [s. 90. (1) (b)]

2. The licensee did not ensure that procedures were implemented to ensure that the temperature of the water serving all showers used by residents did not exceed 49 degrees Celsius, and were controlled by a device, inaccessible to residents, that regulated the temperature.

The home's hot water temperature policy VII.H.10.70 titled "Water Temperature Monitoring" included the requirement to ensure hot water was maintained between 40 and 49 degrees Celsius at sinks, showers and bathtubs to which residents had access. However, further in the policy, under the procedures

section, the registered staff were directed to take water temperatures in tub rooms, public washrooms and resident washrooms, not showers. The water temperature logs maintained by the nursing staff on each floor did not include any temperatures taken at any shower, just at hand sinks in resident rooms and at a sink in each corridor. The temperatures at the hand sinks were recorded to have remained below 49 degrees Celsius for the month of October 2016.

On November 1, 2016, the hot water temperatures were taken of all of the showers located in the home using an accurate digital probe thermometer after a resident reported to an Inspector that the shower water temperatures fluctuated from cold to very hot in a short period of time. The temperatures were recorded to be 52 degrees Celsius in both of the second floor showers and 53 degrees Celsius in one shower on the fourth floor. According to the Environmental Services Supervisor, the hot water serving the resident areas in the home was regulated by one mixing valve. The mixing valve was inaccessible to residents however some question as to whether the valve was working effectively was raised.

Thermometers used by staff to take the water temperatures were identified to be inaccurate or difficult to read. Both bi-metallic probe thermometers used by nursing staff on the first floor were not in good condition, both had faulty dials. The bi-metallic probe thermometer on the second floor had a very narrow scale range on the dial which made it very difficult to get a precise reading. There was some question as to the accuracy of any thermometer as the staff using the thermometers did not know how to calibrate the thermometers and did not know when they were last calibrated for accuracy. The home's policy did not include any calibration instructions, an important component in ensuring that water temperatures were measured accurately to ensure hot water temperatures did not exceed 49 degrees Celsius. [s. 90. (2) (g)]

***Additional Required Actions:***

**CO # - 002, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A1)**
**The following order(s) have been amended: CO# 004**

***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 that ensures that as part of the organized program of maintenance services under clause 15(1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance and procedures are developed and implemented that ensure that, (g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature, to be implemented voluntarily.***

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**WN #3: 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:**
**5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).**

**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:**
**10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**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:**
**11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure there was a process in place to ensure food service workers and other staff assisting residents were aware of the residents' diets, special needs and preferences.

Resident #024 was on an individualized specific diet as ordered by the RD and was at a nutritional risk. Their documented plan of care indicated that the resident was to receive a specific amount of fluids at the lunch meal.

A progress note from an identified date in 2016 indicated that resident #024's family member voiced concern about the resident not receiving the appropriate diet.

Resident #024 received their lunch on an identified date in 2016. Observation and interview with the resident confirmed the fluids that they had received. The

resident confirmed that they were not supposed to receive one of the fluids, yet it was still served to them most days.

Interview with the Director of Dietary Services confirmed that the fluid list, which dietary staff use when serving residents their meals, was not attached to the room service cart, as it should have been. They confirmed that front line staff were not made aware of the resident's special diet needs at meals, resulting in being served inappropriate fluid amounts. [s. 73. (1) 5.]

2. The licensee failed to ensure proper techniques to assist residents with eating, including safe positioning of residents who require assistance, were used.

Lunch service (first and second seatings) were observed on an identified date in 2016. Several concerns were noted regarding improper positioning of residents, as follows:

i. Resident #002 was at a high risk of choking due to dysphagia. The resident's wheelchair was tilted while they were fed their meal. When registered staff #001 was notified, they confirmed the resident should be sitting straight up while eating, and attempted to adjust the resident's chair.
ii. Resident #045's documented plan of care identified the resident had chewing and swallowing risks, and the resident received a texture-modified diet. The resident was observed to be tilted back in their wheelchair while being fed their meal.
iii. Resident #036 was observed to be slid down in their wheelchair.
iv. Resident #037 was at a high nutritional risk due to chewing and swallowing risks. They received a texture-modified diet. The resident was observed with their wheelchair slightly tilted back while being fed their meal.
v. Resident #038 had a chewing problem and received a texture-modified diet. The resident was observed with their wheelchair slightly tilted back while being fed their meal.
vi. Resident #039 had a history of chewing and swallowing difficulty. They required a texture-modified diet. The resident was observed to have slid down in their chair.
vii. Resident #040 was at a high nutritional risk due to chewing and swallowing difficulty and received a texture-modified diet. They were observed in their wheelchair tilted back. Their footrest was inappropriately positioned to be so low that the resident's legs were unable to touch.
viii. Resident #041 was at a high nutritional risk due to a history of chewing

difficulties and required a texture-modified diet. The resident's head rest was observed to be at the back of their lower neck during their meal, pushing their head slightly forward.

In an interview with the RD on November 8, 2016, she confirmed that she had identified issues with improper positioning in the dining room in the past. [s. 73. (1) 10.]

3. The licensee failed to ensure there was appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs for all residents and appropriate seating for staff who are assisting residents to eat.

Observation of the first and second lunch service seatings in the dining room identified the following:

i. Resident #036, was observed in their customized wheelchair. Due to this, the resident was so far from the table that when attempting to feed themselves, they appeared to be struggling to reach the edge of the table to get to their food.
ii. Resident #042 was observed sitting adjacent to their table, and the staff said this was due to the fact that the resident's feet hit into resident #043's feet, which upsets their tablemate and causes them agitation.
iii. Resident #043's feet were observed to be overlapping with resident #044's feet at their table. [s. 73. (1) 11.]

***Additional Required Actions:***

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

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**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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care for resident #007 set our clear directions to staff and others who provide direct care to the resident.

Resident #007 had a diagnosis that resulted in a specific physiological reaction to their body. The resident developed such such a reaction that they would demonstrate specific inappropriate behaviours to manage the pain and uncomfortable nature of the reaction. The physician ordered a prescription for three weeks; however, a plan of care was not developed to direct staff about the care to be provided to manage this. The resident was followed by BSO to address one of the specific behaviours; however, there was not a plan of care to direct the staff how to manage the issues. This was confirmed by lack of documentation, and interviews with the DOC and BSO. [s. 6. (1) (c)]

***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 that ensures there is a written plan of care for each resident that, 6.(1)(c) sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

**WN #5: 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).**

**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,**
**(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:**
**(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,**
**(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and**
**(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were implemented for cleaning of the home, especially in common areas.

The home's housekeeping procedure XII-F-10.60 titled "Dining Room Cleaning Specifications" dated January 2015 described the tasks of cleaning all horizontal surfaces daily (no examples given but this would include heaters and window sills) and on an as needed basis, spot cleaning wall finishes as required to remove food particles and splashes on a daily basis, wiping table bases as required, sweep and wet mop floors and spot wipe doors and frames daily. The

"Housekeeping Cleaning Frequency Schedule" however listed the frequency of cleaning walls semi-annually and window sills and table bases monthly.

The home's housekeeping procedure XII-F-10.10 titled "Window Washing – Inside" dated January 2015 described the task of cleaning window frames annually (or more frequently as required) to prevent soil build up. Procedure XII-E-20.50 titled "Vent Specifications" described the task of dusting vents monthly and deep cleaning yearly.

Based on the observations made over the course of two weeks, the required cleaning tasks were not completed at the frequency suggested and some of the suggested frequencies were not adequate to ensure that the surfaces in the dining rooms and other common areas were kept clean and sanitary.

A) The first floor dining room floor had accumulated debris around the perimeter of the room, behind furniture and under heaters. Dining room table bases were visibly splattered, window sills, frames and heater surfaces were dusty, cobwebbing was noted around the frame of all of the glass exit doors and wall splatter was noted in several areas around the room. Heavy dust accumulation was noted on the return air grills.
B) The third floor dining room had accumulated black dust (soot) on the heater surfaces under the windows, the window tracks were full of dust and a heavy number of dead insects and the return air grill was thick with dust.
C) The fourth floor dining room had splatter on the walls in and around the fridge and where the food cart was routinely parked during meals and the return air grill was thick with dust. The heater surfaces and window sills were heavy with black dust. Some of the chair seats were discoloured. Some of the table bases were splattered.
D) Exhaust grills located in the second, third and fourth floor shower/tub rooms were thick with dust. [s. 87. (2) (a)]

2. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were implemented for cleaning and disinfection of supplies and devices (bed pans, urinals, wash basins) in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with prevailing practices.

According to prevailing practices identified as "Best Practices for Cleaning, Disinfection and Sterilization in all Health Care Settings, 2013" developed by the

Provincial Infectious Diseases Advisory Committee, personal devices that are re-usable such as bed pans and wash basins must be cleaned and disinfected using a low level disinfectant between resident use and subsequently stored in a clean manner. The best practices guide further describes that the reprocessing area is to be designated and separate from resident space and equipped to accommodate staff needs who would be using the space to carry out the processing (cleaning and disinfection).

According to the home's cleaning and disinfection procedure VII-H-10.50 titled "Equipment Cleaning – Resident Care and Medical Equipment" dated September 2016, staff were to clean and disinfect devices after each use, disinfect them weekly by taking the devices to the soiled utility room and applying liquid disinfectant onto the item and to proceed to wash the device thoroughly by using a scrub brush. No details were provided as to what fixture would be used to wash and/or scrub the devices.

The soiled utility rooms located on each of the four floors in the home were not properly furnished or equipped to facilitate staff in the proper cleaning and disinfecting of personal care devices. Each room was equipped with a small hand sink, a hopper (similar to a large flushing toilet) and a free standing large utility sink not connected to any plumbing. The sink, if connected to plumbing would have been an ideal size for submerging devices for proper soaking and cleaning. Counter space and a drying rack/open shelving were not available, however enclosed cabinets were located above the hopper and hand sink. These cabinets were filled with various random items and did not appear clean. No disinfectant or cleaning supplies were provided in these rooms. According to the Director of Care (DOC), personal support workers (PSW) had access to disinfectant wipes for day to day use and housekeeping staff had access to liquid disinfectant for use on touch point surfaces.

The home's procedure was missing specific details about how the devices were to be handled in the absence of an adequately sized sink, space and appropriate disinfectant. A note in the procedure stated that specific cleaning steps would be outlined on a separate cleaning routine. However, no specific cleaning routines were posted in the utility rooms or were available to staff in their communication binders. According to the DOC, night shift PSWs were allocated the task of cleaning the devices, however the DOC was unaware of how the task was conducted or where. After further inquiry, she determined that staff on the various floors were not following any consistent approach and could not effectively clean

the devices as required due to the lack of proper cleaning facilities. Some staff used the tub and tub disinfectant, others used the hand sink and hand soap in the soiled utility room. No monitoring or evaluation of the cleaning and disinfection process was apparent.

Two bed pans were observed to be stored on a grab bar above a toilet in a shared resident washroom on the third floor. Both bed pans were covered with a heavy layer of dust on October 25, 2016 and November 1, 2016. It appeared that the devices were not in use and staff did not ensure that the devices were clean and stored in a clean manner to prevent re-contamination. [s. 87. (2) (b)]

**Issued on this 23rd day of November, 2018 (A1)**

**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**

**Ministère de la Santé et des Soins de longue durée**

## 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

## 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

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Amended Public Copy/Copie modifiée du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by BERNADETTE SUSNIK (120) - (A1) |
| **Inspection No. / No de l'inspection :** | 2016_210169_0016 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 030339-16 (A1) |
| **Type of Inspection / Genre d'inspection :** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Nov 23, 2018(A1) |
| **Licensee / Titulaire de permis :** | Vigour Limited Partnership on behalf of Vigour General Partner Inc.<br>302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Camilla Care Community<br>2250 Hurontario Street, MISSISSAUGA, ON, L5B-1M8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Lilibeth Medina |

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## 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

## 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 Vigour Limited Partnership on behalf of Vigour General Partner 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**

**Ministère de la Santé et des Soins de longue durée**

## 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

## 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

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**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2016_191107_0004, CO #001;

**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 shall complete the following:

1. Amend the home's existing "Restraint/PASD Assessment" form or develop a separate bed safety assessment tool that includes all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". The amended questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and

document whether the alternative was effective or not during an observation period.
2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form and document the assessed results and recommendations for each resident.
3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories that are required to mitigate any identified bed safety hazards.
4. An on-going monitoring process shall be established to ensure that all staff apply the bed rails as specified in the plan of care (i.e. when, on what side and how many).
5. Develop an education and information package for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, whether beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails.

This Order is based upon the above non-compliance and three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity is 2 (potential for harm), the scope is 2 (pattern - more than one resident has not been assessed in accordance with prevailing practices) and the compliance history is 3 (non-compliance previously issued in the same area). A compliance order was previously issued following an inspection conducted October 13 to November 25, 2015.

**Grounds / Motifs :**

1. The licensee did not ensure that where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Long Term Care Homes Inspection Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as

the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined not to be fully developed in accordance with the Clinical Guidance document identified above.  During the inspection, numerous residents were

observed in bed with one or more bed rails applied in the guard position. Many other beds, while unoccupied, were observed with bed rails in the guard position and covered by a blanket. According to records provided, 190 residents out of 237 residents were assessed to require one or more bed rails as a personal assistance services device (PASD) while in bed.

For this review seven residents were randomly selected, all of whom were observed to either have one or more bed rails in use or had care plans indicating that they required one or more bed rails as a PASD.

According to the Director of Care (DOC) and Associate Director of Care (ADOC), residents all received an assessment by registered staff and their conclusions were documented on a form titled Restraint/PASD Assessment V2". The form, when reviewed, included information about the residents' ability to use any device (seat belt, bed rail, table top, tilt wheel chair), the purpose of the device (whether a restraint or a PASD), associated risk factors and whether any previous alternatives were trialled before implementing the device. The form and assessment process however was not specifically geared towards a resident's sleeping behaviours and risks associated with bed rail use, if applied. No guidance was provided to assist the assessor in making any decisions when check boxes were ticked off and what safe interventions or bed system modifications were made if the bed rails were considered unsafe.

The home's procedures titled "Bed Rails" dated June 2016 and "Bed Rail Safety Guidelines" dated April 2016 required registered staff to assess residents' need for the use of a bed rail and entrapment risk. However, neither of the procedures identified what form was to be completed to guide the assessor in making a decision about the resident's overall risk when using one or more bed rails. The procedures directed registered staff to document their decisions in the care plan and in the resident's progress notes after considering a list of factors which were identified in the third paragraph above.

A) The home's clinical assessment process related to bed rails did not include a component related to evaluating the resident's sleep patterns, habits and behaviours while sleeping in bed with or without the application of bed rails. There were no details included in any of the home's procedures as to how the assessment of residents would be conducted. Neither the form or the procedures included

information regarding if/how long residents were to be observed, the dates that they were observed and the specific behaviours that were to be monitored during the observation period. The "Restraint/PASD Assessment" form did not include any questions related to sleep patterns or behaviours. Notations or registered staff decisions were not made in any progress note for any of the seven residents reviewed regarding the resident's overall risk for bed system injury or entrapment.

B) The "Restraint/PASD Assessment" form which included a section where the assessor was to select what alternatives were trialled, did not adequately identify what bed rail alternatives were trialled prior to applying the bed rails if they were indicated for a medical symptom or condition. The form included a section titled "Previous Alternatives" and listed five check boxes to choose from; environmental (lighting, mats, safe wandering areas), activities and programs, alterations to nursing care (bed alarm, scheduled toileting, increased supervision), physiological strategies (pain management) and psychosocial programs and therapies. Several of the alternatives listed were not geared towards bed safety in any way. For three residents (002, 003, 005) reviewed, the "Previous Alternatives" section was not completed. For the remaining four residents that had the alternatives section completed, no details were provided as to what was implemented in place of the bed rail before it was applied and whether it was successful or not before deciding that a hard bed rail was the safest choice for the resident. It appeared that the assessor(s) had selected the alternatives to be used in conjunction with bed rails as opposed to selecting the "alternative" as a replacement for one or more bed rails.

C) The questions included on the assessment form did not include several key questions related to history of rail injury, entanglement, suspension or entrapment, history of climbing over the rails and whether rails were used in the past and why. Relevant questions were noted to include resident's medical diagnosis, cognitive status and risk factors such as involuntary or spasmodic body movements, risk of falls, balance, medication use, and injury to self. Once the assessor checked off the boxes that were relevant to the resident, no further guidance was provided to decide whether the resident was at any risk for entrapment or injury if bed rails were to be applied. Out of the seven residents reviewed, two residents (002, 005) were diagnosed with high risk of falls from bed and seizures and resident 007 was diagnosed with involuntary or spasmodic body movements. Residents 001, 004, 006 and 007 were diagnosed with severe cognitive impairment and required extensive assistance from staff to reposition and turn them while in bed. These risk factors,

according to the Clinical Guidance document are considered high risk, especially when a resident has a combination of risk factors. The care plan for four residents required that staff apply two bed rails while in bed and the other three residents required staff to apply one bed rail while in bed. It did not appear that the risk factors identified were taken into consideration before including bed rails in the residents' individualized care plans.

D) The "Restraint/PASD Assessment" form did not specify what interdisciplinary staff members participated in the clinical bed safety assessment of the resident. The assessment form did not have any staff names listed. However, according to the DOC, registered staff members did not assess residents independently, but routinely asked PSWs for their input in providing information about residents' specific needs while in bed to determine if one or more bed rails would be of any benefit. PSWs used a computerized system called "Point of Care" to document whether they assisted a resident with a transfer in and out of bed or repositioning while in bed.

Both the ADOC and DOC who participated in the completion of the assessment forms reported that they felt pressured by certain SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation. (120)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 30, 2017

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## 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

## 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

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**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

**Order / Ordre :**

The licensee shall prepare and submit a written plan of action to address the condition of the fixtures, surfaces and furnishings identified in the grounds listed in A) to C) below by February 28, 2017. The plan shall at a minimum identify what fixtures, surfaces and furnishings will be replaced or repaired by June 30, 2017, who will complete the work (provide either external company name or whether completed by maintenance staff in home) and what type of work will be completed in order to address the disrepair/condition (i.e whether replaced or repaired). The plan shall be emailed to Bernadette.susnik@ontario.ca.

2. The licensee shall develop a written policy that reflects the goals and maintenance outcomes for the interior of the home. Specific written procedures shall be developed that identifies the surfaces (i.e floors, walls, ceilings, doors, windows), fixtures (i.e toilets, mirrors, sinks, grab bars, tubs, lights) and furnishings (i.e beds, cabinets, wardrobes, chairs, tables, night tables, sofas, blinds, lifts) within the home that need to be monitored for condition and the acceptable condition expectations, who will monitor them and how often, who will be responsible for repairing the surfaces, fixtures and furnishings and the expected time frames for repair or replacement. The procedures shall be implemented.

This Order is based upon the above non-compliance and three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity is 2 (potential for harm), the scope is 2 (pattern) and the compliance history is 2 (previous non-compliance unrelated ).

**Grounds / Motifs :**

1. As part of the organized program of maintenance services under clause 15(1)(c) of the Act, the licensee of a long term care home did not ensure that there were schedules and procedures in place for remedial maintenance.

A) The cabinet doors located in various areas throughout the home such as in dining rooms and in corridor niches (near the nurse's stations) had worn or rough surfaces. A cabinet door under the hand sink in the fourth floor dining room was rough around the edges as the laminate had peeled. The wood cabinet surfaces under the counter in the first, third and fourth floor corridor niches were worn down to raw wood. A portable cabinet unit in the first floor dining room used to store meal aprons was in poor condition, with the top counter section cracked and split. No schedule was in place to remediate the condition of the cabinets and no procedures had been developed to ensure that they were maintained in good condition.

B) Approximately 40 night tables were noted to be in poor condition in resident rooms on all floors. The night tables, made of particle board with a laminate overlay, had exposed particle board along the top front edge of each night table that was very rough. Other night tables were observed to have had an obvious repair made, using an off white wood filler in areas where the laminate had deteriorated and the top surface re-varnished. The result was unsightly but smooth for cleaning purposes. No confirmation could be provided by the home as to whether new tables would be purchased or if there was a schedule in place to replace them. No procedures had been developed to ensure that the night tables were maintained in good condition.

C) Other maintenance issues identified included roller blinds not in good condition on third floor (could not be used as the mechanism to pull the blind up was missing), the plastic bi-fold closet doors in #322 were torn from the pins that held up the doors, the stools used by staff in the various dining rooms were in poor condition, with cracked or split seat covers, flooring material in washroom #331 in front of the toilet area was worn down to the wood sub layer and the fixed grab bars located in washrooms #326, 423, 431, 433 and the portable grab bars attached to the raised toilet seat in washroom #328 were rusty.
(120)

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## 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

## 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 :** Jun 30, 2017

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

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**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. 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

**Order / Ordre :**

The licensee shall ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

Specifically, the licensee shall ensure that:
1. All direct care staff that are responsible for assisting with meal time in the dining room on the fourth floor are provided with re-training regarding appropriate positioning of residents in their wheelchairs during meal time;

2. All direct care staff are aware of the positioning requirements in the plan of care for all residents on the fourth floor;

3. All residents receive care as per their plan of care related to proper positioning during meal time, and other times of day, to support their comfort. This is to include ensuring that residents are seated at tables that are at an appropriate height and distance from each resident to support their eating needs;

4. A reassessment of residents' #039 and #040 in their wheelchairs by the occupational therapist, or other appropriate person.

The Order is based upon the above non-compliance and three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity is 2 (potential for harm), the scope is 2 (pattern) and the compliance history is 3 (previously WN in similar area).

**Grounds / Motifs :**

1. The licensee failed to ensure proper techniques to assist residents with eating, including safe positioning of residents who require assistance, were used.

Lunch service (first and second seatings) were observed on an identified date in 2016. Several concerns were noted regarding improper positioning of residents, as follows:

i. Resident #002 was at a high risk of choking due to dysphagia. The resident's wheelchair was tilted while they were fed their meal. When registered staff #001 was notified, they confirmed the resident should be sitting straight up while eating, and attempted to adjust the resident's chair.
ii. Resident #045's documented plan of care identified the resident had chewing and swallowing risks, and the resident received a texture-modified diet. The resident was observed to be tilted back in their wheelchair while being fed their meal.
iii. Resident #036 was observed to be slid down in their wheelchair.
iv. Resident #037 was at a high nutritional risk due to chewing and swallowing risks. They received a texture-modified diet. The resident was observed with their wheelchair slightly tilted back while being fed their meal.
v. Resident #038 had a chewing problem and received a texture-modified diet. The resident was observed with their wheelchair slightly tilted back while being fed their meal.
vi. Resident #039 had a history of chewing and swallowing difficulty. They required a texture-modified diet. The resident was observed to have slid down in their chair.
vii. Resident #040 was at a high nutritional risk due to chewing and swallowing difficulty and received a texture-modified diet. They were observed in their wheelchair tilted back. Their footrest was inappropriately positioned to be so low that the resident's legs were unable to touch.
viii. Resident #041 was at a high nutritional risk due to a history of chewing difficulties and required a texture-modified diet. The resident's head rest was observed to be at the back of their lower neck during their meal, pushing their head slightly forward.

In an interview with the RD on November 8, 2016, she confirmed that she had identified issues with improper positioning in the dining room in the past. (586)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 23, 2017

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

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## 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

## 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

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**Order # / Ordre no :** 004

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

**Order / Ordre :**

The licensee shall replace or remediate all windows located on the 1st floor, 2nd floor and a portion of the 3rd floor that are not tight-fitting when closed to prevent rattling and air infiltration from the exterior into the building.

The inspector shall be contacted a minimum of 30 days before the compliance due date if any changes to the original submitted plan or compliance dates are required.

This Order is based upon the above non-compliance and three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity is 2 (potential for harm), the scope is 2 (pattern) and the compliance history is 2 (previous non-compliance unrelated ).

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**Grounds / Motifs :**

1. As part of the organized program of maintenance services under clause 15(1)(c) of the Act, the licensee of a long term care home did not ensure that there were schedules and procedures in place for remedial maintenance.

The majority of the aluminum slider-type windows located throughout the home (except on fourth floor and some windows on third floor) were not maintained to ensure that they could provide an adequate seal to keep out drafts. The windows were not tight-fitting when closed due to the complete deterioration of the felt seals that once existed around the perimeter of the frames. The windows rattled in the wind and permitted air drafts to enter the room. No procedures were developed to address the care and maintenance of the windows and no schedules were in place to either repair or replace the windows in the near future.

(120)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 02, 2019(A1)

## 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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

## Order(s) of the Inspector

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Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  23rd  day of November, 2018 (A1)**

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

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

Amended by BERNADETTE SUSNIK (120) - (A1)

Ontario

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