Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 5, 2015	2015_301561_0004	H-001939-15	Resident Quality Inspection

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

FAITH MANOR NURSING HOME
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

DARIA TRZOS (561), CATHIE ROBITAILLE (536), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)

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): February 5, 6, 10, 11, 12, 17, 18, 19, 20, 23, and 24, 2015

The following log numbers were completed with this inspection: H-000256-14, H-001233-14 and H-001414-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), Maintenance Manager, Maintenance Supervisor, Housekeeping/Laundry Manager, Activity Director, Social Worker, Human Resources, Nutrition Manager, Family Council Representative, Resident Council President, Registered Staff including Registered Nurse (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), dietary aides, housekeeping staff, family members and residents.

During the course of the inspection, the inspectors toured the home, observed the provision of care, observed the meal service, reviewed health care records, reviewed relevant policies, procedures and practices, laundry, maintenance and housekeeping practices, and food production systems, interviewed residents, family members and staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **24 WN(s)**
- **20 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (2)	CO #003	2013_205129_0014	561
O.Reg 79/10 s. 90. (2)	CO #002	2014_207147_0006	561

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of PASD (Personal Assistance Services Device) to assist a resident with a routine activity of living was included in resident's plan of care only if the following were satisfied: alternatives to the use of the PASD, consent was obtained and the device was approved.

A) An order was previously issued for this non-compliance in April 2014 with a compliance date of April 30, 2014.

B) The home had submitted a plan of action to the Ministry of Health and Long-Term Care in April, 2014 that included short term and long term actions. In the plan the home had identified that the immediate action the home undertook was further development of

the PASD package and alterations to policy to meet the legislation requirement. The PASD package was to contain assessment, use of alternatives, consent and evaluation of PASD. The plan also indicated that this package was already posted and staff were instructed on the implementation and use of the PASD.

C) Health records of three residents were reviewed on February 18, 2015 and indicated the following:

i) Resident #035 used one side rail up when in bed as a PASD for comfort and to assist with bed mobility as needed
ii) Resident #040 used two upper half rails when in bed as a PASD for comfort and to assist with bed mobility
iii) Resident #100 used one side rail up when in bed as a PASD for comfort and to assist with bed mobility

Interview with registered staff indicated that there were no assessments completed and alternatives to the use of PASDs were not considered prior to the application of the PASD for the three residents.
The health care records did not include the approval of the PASD by an appropriate person as defined in the legislation nor was consent documented as being obtained from the resident for the use of the PASD.

D) The registered staff members that were interviewed were not aware of legislative requirements related to PASDs. Interview with the Director of Resident Care (DRC) confirmed that the PASD package as identified on the action plan was still in the development stages and was not in use. The DRC also confirmed that the requirements for the use of PASDs as specified in the legislation were not completed for the residents identified. [s. 33. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 use of PASD (Personal Assistance Services Device) to assist a resident with a routine activity of living is included in resident's plan of care only if the following were satisfied: alternatives to the use of the PASD have been considered, consent was obtained and the device was approved., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used,
a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices to minimize risk to residents
b) steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment

A) An order was previously issued for this non-compliance with the compliance date of October 31, 2014. An immediate order dated March 14, 2014 was also issued for not ensuring that steps were taken to minimize the risk for all entrapment zones for beds: F204-1, F207-B and F125-A.

B) The home had submitted an action plan to the Ministry for Health and Long Term Care in April, 2014 identifying the short and long term actions in order to meet the legislative requirements.

The short term action identified by the home was to complete the audit by May 2014 of all beds in the home and assess the use of all bed rails to ensure resident safety. The long term action was to establish a detailed plan to track all risks/potential risks and fix or replace any entrapment safety issues. The plan to fix or replace all beds was to be completed by October 2014. There was no indication that the home had rectified all the beds that failed the zones of entrapment in 2014.

C) The record review and the interview with the DRC on February 18, 2015, indicated that the bed entrapment zone audit was completed in June 2014 by the DRC. The results of the audit concluded that 47 percent (%) of the beds failed one or more zones of entrapment which could potentially cause injury to the resident. The audit sheet did not indicate which zones had failed. The DRC had completed another audit on January 16, 2015 and February 13, 2015. The audit sheet indicated that out of 120 beds in the home only 16 passed the entrapment risk assessment for zones. The DRC confirmed that a number of new beds and 8 new mattresses were ordered but not yet received. There was no indication that the home had rectified all the beds that failed the zones of entrapment.

D) During stage 1 of the Resident Quality Inspection that commenced on February 5, 2015, and during the tour of the home there was a number of beds that had gaps between head boards and mattresses, between the top and bottom bed rails and between bed rails and mattresses. Some beds were furnished with quarter length assist bed rails and others with older full length rails. Some of the headboards and rails were wiggling and others had no mattress keepers to keep the mattresses from sliding.

E) At the time of this inspection, the home removed some of the bed rails from residents' beds that did not require bed rails. The DRC reported that the home did not have a system in place to determine which residents required bed rails and the staff were applying the bed rails for residents that did not require them.

F) On February 19, 2015, the Maintenance Manager and Maintenance Supervisor confirmed that the home did not have a policy in place for bed rails and entrapment zones prior to the RQI that commenced on February 5, 2015. The “Entrapment – Bed

Rails" policy was developed and implemented in the home on February 13, 2015.

The home did not ensure that all residents were assessed, their bed systems were evaluated to minimize risk to residents and steps were taken to prevent resident entrapment taking into consideration all potential zones of entrapment after the order was issued to the home in March 2014. [s. 15. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 where bed rails are used, all residents are assessed and their bed systems are evaluated in accordance with evidence-based practices to minimize risk to residents, and steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that training related to continence care and bowel management was provided to all staff who provide direct care to residents on either an annual basis, or based on the staff's assessed training needs.

Review of the plan of care for resident #042 and #007 was unable to determine when the residents' were assessed for continence and what strategies were implemented based on the assessments. Interview with the registered staff confirmed they were unsure of

what assessment tool designed for continence care was utilized in the home. The staff were also unsure of their home's policy and procedures, and when they were last trained in continence care. When the DRC was interviewed, who is also the lead for the Continence Care Program, stated that many of the elements of the Continence Care Program were not implemented and was a work in progress. The DRC identified that the number of direct care providers trained in the Continence Care Program was low. The Education and Human Resources Coordinator confirmed that there was 49.2% of PSWs trained in continence care; 31.6% RPNs trained in continence care; and 50% RNs trained in continence care. Overall the percentage of direct care providers in the home trained in 2014 in continence care was 43.6%. [s. 221. (1) 3.]

2. The licensee has failed to ensure that all staff who apply physical devices or who monitor residents restrained by a physical device, including: application of these physical devices; use of these physical devices, and potential dangers of these physical devices were trained.

On two identified dates in February 2015 resident #022 was observed to have a loose seat belt and the resident was unable to undo the seat belt. When interviewing the PSWs and registered staff, they were unsure of the correct application of the seat belt for resident #022; they did not know what the manufacturer's instructions were for the application of the seat belt and the use of the tilt wheelchair; they did not identify that the resident had a tilt wheelchair restraint; they were not familiar with the home's policies and procedures for Least Restraints; and they were not able to identify the potential dangers of the restraints used for this resident. When reviewing the staff training for Minimization of Restraints for 2014 it was identified that only 52% of staff were trained. Not all the registered staff and PSWs could confirm they had received training in this past year. The ADRC confirmed that not all staff who apply physical devices, or who monitor residents restrained by a physical device were trained in 2014. [s. 221. (1) 5.]

3. The licensee has failed to ensure that training was provided to all staff who provided direct care to residents, including training for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

A) A previous order was issued for this non-compliance in relation to training for staff who apply PASDs.

B) The home had submitted an action plan to the Ministry of Health and Long Term Care in April 2014. The action plan indicated that the Nursing Staff including registered staff

and PSWs will have mandatory PASD education through Surge Learning to be completed within 30 days.

C) The home's training records and the ADRC confirmed that only 52% of direct care providers received training in the application, use and potential dangers of the PASDs in the year 2014. The interview with registered staff members indicated that they were not aware of the requirements for PASDs as specified in the legislation. [s. 221. (1) 6.]

4. The licensee has failed to ensure that all staff who provide direct care to residents, received training relating to abuse recognition and prevention annually, and as a condition of continuing to have contact with residents (s. 76(7)).

A) The HR Coordinator and DRC confirmed that 29 PSW/Nursing Aides, 25 RPNs, and 14 RNs, had not completed the training between January 1 - December 31, 2014 (active staff members only).

B) The HR Coordinator and DRC confirmed that direct care staff who had not completed the mandatory training on the prevention of abuse and neglect were not prevented from working with residents.

C) An identified PSW who was involved in an alleged verbal abuse of a resident had not completed the mandatory abuse recognition and prevention training in 2014 and was allowed to continue working with residents. The training was not provided/completed after the alleged incident and the staff member did not have an assessment of their training needs to identify alternative learning needs. [s. 221. (2)]

Additional Required Actions:

CO # - 003, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 training is provided annually to all staff who provide direct care to residents related to continence care and bowel management, abuse recognition and prevention, that all staff who apply physical devices or who monitor residents restrained by a physical device, including: application of these physical devices; use of these physical devices, and potential dangers of these physical devices, training for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's Administrator works regularly in that position on site at the home at least 35 hours per week.

A Written Notification was previously issued for this non-compliance on February 3, 2014.

In the previous non-compliance issued to the home evidence indicated and confirmed by the Management Board chair person and the Executive Director/Administrator that the Administrator of the home holds dual responsibilities for the administration of Faith Manor as well as the overall administration of Holland Christian Homes Incorporated. Dual role would not allow the Administrator to work regularly in the position of Administrator of Faith Manor for a least 35 hours per week. The Executive Director/Administrator confirmed that his role within the corporation includes overall responsibility for two 120 bed Long Term Care Homes and a complex that includes 641 apartments over six buildings many of which have some form of assisted living arrangements including meals on wheels operations.

Interview with the Administrator and the Director of Resident Care on February 23, 2015, confirmed that the Administrator role has not changed since the non-compliance was previously issued. The Administrator also confirmed that the Administrator duties and responsibilities were shared among the DRC and the ADRC who covered part of the 35 hours per week requirement. [s. 212. (1) 3.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's Administrator works regularly in that position on site at the home at least 35 hours per week., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 2. Every resident has the right to be protected from abuse.

A) Resident #301 was not protected from abuse. Documentation in the resident's progress notes from an interview between the home's Social Worker and the resident indicated that the staff member yelled and told the resident to get up. The resident was afraid of this staff member who was intimidating and spoke in a loud voice.

B) The identified staff member was disciplined by the DRC, as indicated on the written interview notes between the DRC and PSW. [s. 3. (1) 2.]

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 following rights of residents are fully respected and promoted: 2. Every resident has the right to be protected from abuse., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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 home has failed to ensure that the written plan of care set out clear direction to staff and others who provided direct care to the resident.

A) Resident #100's written plan of care indicated that the resident required "one side rail up for their comfort and to assist with bed mobility". The audit for bed rails and entrapment zones that was completed by DRC on February 13, 2015 indicated that resident #100 had four half rails on the bed and resident did not want them removed. The written plan of care did not indicate which side rail was to be in the up position. Registered staff confirmed that the PSWs follow the written plan of care to guide care for each resident. The written plan of care did not provide clear direction to staff as to which side rail to apply for the resident.

B) Resident #101's written plan of care was reviewed and indicated that the resident required one "side rail up for their comfort and to assist with bed mobility". Another section of the written plan of care indicated that the resident required "2 side rails up while in bed for safety". The registered staff confirmed that the PSWs use written plans of care to guide the care for residents. The plan of care did not provide clear direction to staff as to whether the resident required one or two rails while in bed. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #300 was provided to the resident as specified in the plan.

The resident's plan of care for September 2014, identified the resident had a history of "severe wandering". The plan required one to one monitoring until the resident's anxiety decreased and safety checks every 15 minutes. Documentation in the progress notes and interview with the DRC and RPN working on an identified date in October 2014, confirmed that the staff assigned to monitor the resident, left the resident unattended to take a washroom break of an identified date in October 2014. The resident was able to elope from the building. [s. 6. (7)]

3. The licensee has failed to ensure that the following are documented: 1. The provision of the care set out in the plan of care.

Resident #022 wore a seat belt restraint. The plan of care identified that the resident was to be checked hourly for the status of the restraint and positioning changes. The home's policies were reviewed and identified that the PSWs were to document on the Restraint Monitoring Form hourly and outlined the documentation requirements. In reviewing the resident's clinical record it was identified that there was no documentation for 16 days between the months of January and February 2015.

The ADRC, PSWs and registered staff confirmed the PSWs were to document hourly checks of restraint status and positioning change on the restraint form. The PSWs confirmed they sometimes forget to document in the Restraint form as per the home's policy and procedure. [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 written plan of care sets out clear direction to staff and others who provide direct care to the resident, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #7: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The policy called "Continence Care Program", number 30-01-33, and reviewed on August 21, 2013 directed registered staff to do the following:

- Residents will be assessed when there was a change in their condition that affects continence and at least quarterly.
- Resident who were continent or who had been assessed as having the potential for continence shall have an individualized plan of care that maintains and promotes continence.
- A disposable incontinence system will be used in conjunction with bladder and bowel retraining programs.

In review of the clinical records for resident #042 and resident #007 there were no assessments when there was a change in their condition which affected continence. There were no individualized plans of care to maintain or promote continence, and there was no bladder or bowel retraining programs identified. The registered staff and the DRC confirmed that the home's Continence Care Program policy was not complied with.

B) The home's policy called "Lift Pre-Use Inspection", and revised September 19, 2014, indicated that "at the beginning of each shift PSW who will be using the lift for that shift shall review the Pre-Use Checklist and undertake the process prescribed on the checklist

prior to using the lift.
The registered staff member responsible for the floor/unit shall complete the Pre-Use Inspection Audit checklist daily. The registered staff member is responsible for ensuring that the Pre-Use Inspection Checklist has been completed by the PSW".

The binder with the completed Lift Inspection Audit Checklists was reviewed on both floors of the home and identified that not all registered staff completed these audits on daily basis in the months of January and February, 2015. The Lift Inspection Audit Checklists indicated that 15 days out of 60 days reviewed had not had the checklists completed and signed by registered staff on the first floor. There were 20 days out of 60 days reviewed that did not have the inspection audits completed by registered staff on the second floor.

The registered staff indicated that it is an expectation of registered staff to complete the Lift Inspection Audit Checklists on day and evening shifts and confirmed that they were not always completed. The DRC confirmed that the policy and procedure was not followed by staff. [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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

On an identified date in 2014, resident #300 was able to elope from the building and was found by staff off the premises. The resident's plan of care, identified the resident had a history of "severe wandering". The plan of care also required one to one supervision and 15 minute safety checks. According to documentation, and interview with the DRC and RPN working the day of the elopement, the PSW assigned to the resident left the resident alone and when they returned, the resident had disappeared. During interview on February 20, 2015, the RPN working on the unit on the day of the incident, stated that staff checked all the doors on the floor and the only door found unlocked and ajar was the door from the dining area to the servery. Progress notes confirmed that the RPN was the person who found the door to the servery unlocked and unattended. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During Stage 1 of the RQI on February 5 and 6, 2015 the Long Term Care (LTC) Inspector noted common areas, which were in disrepair.

A) On 2A Wing the shower room had an orange coloured resident chair located in the shower room with all four legs rusted. In the same shower room there was a wooden foot stool, which was used to elevate residents' feet while the PSWs assist with their dressing, the wooden foot stool had black markings in various areas of the wooden legs and the lacquer was worn off.

B) On 2B Wing in the shower room there was a dark brown coloured wood cabinet and the wood was lifted on all four legs and the particle board was exposed.

C) The floor in front of the nursing station on the 2nd Floor had an area where the flooring joined. There was a six inch by one inch piece of the flooring missing and the ragged edges where lifting, therefore creating a trip hazard for residents ambulating and/or using mobility aids to walk.

The Maintenance Manager confirmed there was no log identifying these repairs were needed, and there was no schedule for them to be repaired. The Maintenance Manager also confirmed that the home does not have a preventative maintenance schedule to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (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 to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with for an incident that occurred on September 7, 2014 and reported on September 8, 2014.

The home's policy called "Investigation of Resident Abuse or Neglect", number 60-07-08, dated August 31, 2014, stated:
1. The team (Abuse Investigation Team) shall endeavour to complete the following tasks as soon as possible after convening:
a) Obtain a signed written statement from the resident if they are able, the employee, and any other person witnessing or having knowledge of the alleged abuse or neglect.

The home's policy called "Reporting of Resident Abuse or Neglect", number 60-07-06, dated August 31, 2014, stated:
1. If the investigation determines that abuse did not occur the team will decide what action to take, and the staff member will return to work only after receiving one-to-one education regarding the HCH abuse policies from a designated member of the team.

The home's policy called "Resident Abuse and Neglect" that was included with the home's abuse policies and provided to the inspector (no date or number) stated:
1. Staff will be trained on the resident abuse policies during orientation, and annually thereafter. Attendance at the mandatory in-services will be tracked in a data base, and staff not in attendance will be assigned the training via an alternate format. Staff who do not complete the mandatory in-services within 30 days of being assigned the training will be subject to the progressive discipline process.

The home did not comply with their zero tolerance of abuse and neglect policies stated

above.

A) A staff member was accused of verbal abuse of a resident one day after the incident occurred. The DRC confirmed that a signed written statement was not obtained from the PSW involved in the incident.

B) The DRC confirmed that the PSW did not receive one-to-one education regarding the HCH abuse policies from a designated member of the team. The PSW identified in the incident had not completed the mandatory annual prevention of abuse and neglect training for the year of 2014.

C) The DRC and Human Resources Coordinator confirmed that the PSW involved in the incident had not completed the mandatory prevention of abuse and neglect training and confirmed that the PSW was not subject to the disciplinary process as a result of not completing the mandatory training. [s. 20. (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 home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).

2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

(e) the resident is restrained only for as long as is necessary to address the risk referred to in paragraph 1 of subsection (2); 2007, c. 8, s. 31 (3).
(f) the method of restraining used is discontinued if, as a result of the reassessment of the resident's condition, one of the following is identified that would address the risk referred to in paragraph 1 of subsection (2):
(i) an alternative to restraining, or
(ii) a less restrictive method of restraining that would be reasonable, in light of the resident's physical and mental condition and personal history; 2007, c. 8, s. 31 (3).
(g) any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint by a physical device as described in paragraph 3 of subsection 30 (1) was included in the resident's plan of care.

A) Resident #003 was observed wearing a seat belt, which was incorrectly applied. The resident was cognitively impaired and was unable to undo the seat belt. A review of the resident's plan of care identified that the restraint was not included in the plan of care. The registered staff and PSWs were interviewed and they stated the resident does not wear a restraint. The registered staff and PSWs confirmed they were unaware the resident was wearing a restraint and that it was not included in the resident's plan of care.

B) Resident #022 was observed in the tilted position in their wheelchair with a seat belt in place. The resident was unable to rise or change position. After reviewing the resident's clinical record there was no order or consent for the tilted wheelchair to be used as a restraint. In reviewing the Minimum Data Set (MDS) assessments in 2014 the resident was assessed as using a chair which prevents rising. The Quarterly Physical Review for Use of a Physical Restraint, which was completed by the registered staff, the physician and the resident's substitute decision maker identified that the resident uses a tilt chair as a restraint. The written plan of care did not include the tilt wheelchair restraint used by the resident. This was confirmed by the registered staff, the PSWs and the ADRC. [s. 31. (1)]

2. The home failed to ensure that restraining of a resident by a physical device was included in the resident's plan of care and the following were satisfied: 1. There is a

significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 6. The plan of care provides for everything required under subsection (3).

Resident #003 was observed wearing a seat belt which was applied incorrectly. The resident's clinical record confirmed there was no order approved for restraining. There was no consent for the restraint on the resident's clinical record. There was no restraint by a physical device assessment or monitoring documented in the resident's clinical record. There was no documentation of alternatives to restraining in the resident's clinical record. The registered staff and PSWs confirmed there was no order for approval of the restraint; no consent obtained; no alternatives considered; there was no restraint assessment; there was no safety monitoring; and the resident should not be wearing a restraint. [s. 31. (2)]

3. The licensee has failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but have not been effective in addressing the risk.

The restraint plan of care for resident #022 did not include the tilt wheelchair. The seat belt restraint was included in the plan of care; however it did not identify alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk. In addition, the quarterly physical restraint reviews completed by the interdisciplinary team and Substitute Decision Maker (SDM) on identified dates in 2014 did not include alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk. In reviewing the progress notes from February 2014 to February 2015, there was no documentation related to alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk. This was confirmed by the registered staff and the ADRC. [s. 31. (2) 2.]

4. The licensee has failed to ensure that the restraint plan of care included an order by

the physician or the registered nurse in the extended class.

Resident #022 was observed on three identified dates in February 2015 in the tilted position in their wheelchair with a seat belt in place. The resident was unable to rise or change position. After reviewing the resident's clinical record there was no order for the tilted wheelchair to be used as a restraint by a physician or the registered nurse in the extended class. In reviewing the MDS assessments the resident was assessed as using a chair which prevents rising. The Quarterly Physical Review for Use of a Physical Restraint, which was completed by the registered staff, the physician and the resident's substitute decision maker identified on identified dates in 2014 that the resident used a tilt chair as a restraint. The registered staff and ADRC confirmed there was no order for tilt wheelchair to be used as a restraint. [s. 31. (2) 4.]

5. The licensee failed to ensure that if a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that, (a) the device is used in accordance with any requirements provided for in the regulations; (b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; (c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; (d) the resident’s condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations; (e) the resident is restrained only for as long as is necessary to address the risk referred to in paragraph 1 of subsection (2); (f) the method of restraining used is discontinued if, as a result of the reassessment of the resident’s condition, one of the following is identified that would address the risk referred to in paragraph 1 of subsection (2): (i) an alternative to restraining, or (ii) a less restrictive method of restraining that would be reasonable, in light of the resident’s physical and mental condition and personal history; and (g) any other requirements provided for in the regulations are satisfied.

Resident #003 was observed wearing a seat belt on three different occasions in February 2015. It was identified from the interviews with the PSWs and the registered staff that there were no hourly safety checks of the restraint status and no positioning changes for the resident. The LTC Inspector was able to fit two hands between the resident's trunk and the seat belt. The staff confirmed the resident's seat belt was incorrectly applied and was not applied according to the manufacturer's instructions. The staff also confirmed there was no restraint assessments conducted for the use of the restraint on the resident and there was no evaluation to determine its effectiveness. A review of the resident's clinical record confirmed there was no documentation that the device was used in

accordance with any requirements provided for in the regulations. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraint by a physical device as described in paragraph 3 of subsection 30 (1) is included in the resident's plan of care and that the following are satisfied: 1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 6. The plan of care provides for everything required under subsection (3), to ensure that the restraint plan of care includes an order by the physician or the registered nurse in the extended class, and that the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations;, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that in addition to meeting the requirements set out in section 30, (a) provide for screening protocols; and (b) provide for assessment and reassessment instruments.

The Continence Care Program identifies the legislative requirements in their policies and procedures; however there was no provision for assessment and reassessment instruments. In reviewing the clinical records for resident #042 and resident #007, there was no assessment or reassessment instruments used when both residents' continence had worsened and there was a change in condition, which impacted continence abilities. The registered staff and the DRC confirmed the Continence Care Program did not provide for assessment and/or reassessment instruments. [s. 48. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that in addition to meeting the requirements set out in section 30, (a) provide for screening protocols; and (b) provide for assessment and reassessment instruments, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A) The MDS assessment on an identified date in 2014 indicated that the resident #042 was occasionally incontinent of urine, and the resident was continent for bowels. The next MDS quarterly assessment identified the resident status changed and their incontinence worsened. The resident became frequently incontinent of urine, and became occasionally incontinent for bowels. On an identified date in 2015 the MDS assessment identified the resident had become incontinent of urine at all times, and the resident became frequently incontinent for bowels. The resident had a change in condition and there was no assessment conducted that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that an assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. In review of the clinical record there was no assessment for incontinence. In review of the home's policy named "Continence Care Program", number 30-01-33, and reviewed August 21, 2013 directed staff that they were to assess the resident when there was a

change in their condition that affected continence. The registered staff and the DRC confirmed the resident was not assessed using a clinically appropriate assessment tool for continence and that the home currently does not have a continence assessment tool in place.

B) The MDS assessment in October 2014 identified that the resident #007 was frequently incontinent of urine, and the resident was occasionally incontinent for bowels. The MDS assessment in January 2015 identified the resident status changed and their urinary incontinence worsened. The resident had a change in condition and there was no assessment conducted that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that an assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. In review of the clinical record there was no assessment for incontinence. In review of the home's policy named "Continence Care Program", number 30-01-33, and reviewed August 21, 2013 directed staff that they were to assess the resident when there was a change in their condition that affected continence. The registered staff and the DRC confirmed the resident was not assessed using a clinically appropriate assessment tool for continence and that the home currently does not have a continence assessment tool in place. [s. 51. (2) (a)]

2. The licensee has failed to ensure that each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time.

Resident #042 had worsening urinary and bowel incontinence based on the MDS assessments for three quarters. The home's policy called "Continence Care Program:, number 30-01-33, and reviewed August 21, 2013 identified that residents who were continent or who had been assessed as having the potential for continence should have an individualized plan of care that maintains and promotes continence. In addition, one of the goals of the home's continence program was to establish a program for each resident who exhibits signs of incontinence of bladder and/or bowel in order to assist the resident in regaining urine and/or bowel control or to provide a means of maintaining their dignity. Although resident #042 had worsening urinary and bowel incontinence there was no restorative interventions implemented to assist the resident in achieving continence or prevent worsening. The registered staff confirmed the consultation with the Restorative Care nurse; however it was to identify strategies to manage the worsening incontinence and not to identify strategies to assist the resident in becoming continent, or to become continent some of the time. [s. 51. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is incontinent is assessed and receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that it responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The president of Residents' Council confirmed on February 11, 2015, that the responses related to concerns or recommendations were reviewed at next scheduled Residents' Council meeting. On February 11, 2015 the Inspector reviewed the Residents' Council minutes for 2014 with the Executive Director. The Executive Director confirmed that responses ranged from ten days to twenty nine days. [s. 57. (2)]

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 it responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure it responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

On February 11, 2015, the home's Social Worker, the appointed assistant to the Family Council confirmed, that the responses related to concerns or recommendations were reviewed at the next scheduled Family Council meeting. On February 11, 2015, the Inspector reviewed the Family Council minutes for 2014 with the Executive Director. The Executive Director confirmed that responses ranged from ten days to sixty days. [s. 60. (2)]

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 it responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protections.

The Human Resources (HR) Coordinator stated that all staff of the home were required to complete this training either with a live in-service training session or on-line through their "Surge" learning program if they were unable to attend the live training. The HR Coordinator confirmed that they tracked attendance and completion of the training programs and verified that 72.6% of staff had completed the training and 27.4% had not received the mandatory training. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff receive retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protections, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

On February 11, 2015, the president of Residents' Council confirmed that the home did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. This was also confirmed on February 11, 2015, by the Executive Director. [s. 85. (3)]

2. The licensee has failed to ensure that they seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

On February 11, 2015, the Executive Director confirmed that the home did not seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results. This was also confirmed in review of the 2014 Family Council minutes. [s. 85. (3)]

3. The licensee has failed to ensure that the results of the satisfaction survey were made available to the Residents' Council in order to seek the advice of the Council about the survey.

On February 11, 2015, the president of the Residents' Council and the Director of Care confirmed that the results of the satisfaction survey were not made available to the Residents' Council in order to seek the advice of the Council about the survey. This was also confirmed in the review of the 2014 Residents' Council Minutes. [s. 85. (4) (a)]

4. The licensee has failed to ensure that the results of the satisfaction survey were made available to the Family Council in order to seek the advice of the Council about the survey.

On February 11, 2015, the Director of Care confirmed that the results of the satisfaction survey were not made available to the Family Council in order to seek the advice of the Council about the survey. This was also confirmed in the review of the 2014 Family Council Minutes. [s. 85. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that licensee seek the advice of the Residents' Council and Family Council in developing and carrying out the satisfaction survey, and in acting on its results and to ensure that the results of the satisfaction survey were made available to the Residents' Council and Family Council in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvement were required to prevent further occurrences.

The DRC confirmed that an evaluation of the effectiveness of the home's policy to promote zero tolerance of abuse and neglect of resident and what changes and improvements were required to prevent further occurrences had not been completed for 2014. The DRC also confirmed the evaluation completed in 2013 was not comprehensive and did not include changes or improvements required to prevent further occurrences. [s. 99. (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 at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvement are required to prevent further occurrences, to be implemented voluntarily.

WN #19: 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).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

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

Resident #022 was observed wearing a seat belt on three different occasions in February 2015. The resident was unable to remove the seat belt. When interviewing the PSWs and the registered staff they were unsure what the manufacturer's instructions were for the correct application of the seat belt, and they were not able to locate the instructions on their unit. The manufacturer's instructions were subsequently provided to the LTC Inspector and reviewed with staff. The instructions identified that the practice was to allow just enough space for two fingers to fit between the seat belt and the person's body, at any one point along the belt. The LTC Inspector was able to put 1 1/2 hands between the resident and the seat belt. The seat belt was not applied correctly and in

accordance with the manufacturer's instructions. [s. 110. (1) 1.]

2. The licensee has failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Resident #022 was observed wearing a seat belt restraint on three different occasions in February 2015. The home's policy called "Least Restraints - Use and Application", number 30-06-03A, and reviewed February 5, 2013 directs the registered nursing staff to document on the electronic Medical Administration Record (eMAR) every 12 hours the assessment related to the resident's need for the restraint. The plan of care directs registered staff to review the requirement for the restraint and assess if safety could be achieved with an alternative safety device. The eMAR for three identified months in 2014 and 2015 were reviewed and there was no documentation of the assessment related to whether or not the restraint was necessary and if not, if safety could be achieved with an alternative safety device. The registered staff confirmed that what they were signing for on the eMAR was related to checking the restraint to ensure it is correctly applied while the resident was in the wheelchair, and if the resident was safe and comfortable. The ADRC confirmed that registered staff were expected to document in eMAR as per the home's policy and that the assessment would include alternatives to restraining. [s. 110. (2) 6.]

3. The licensee has failed to ensure that the documentation include what alternatives were considered and why those alternatives were inappropriate.

Resident #022 was observed on three different occasions in February 2015 wearing a seat belt as a restraint and also a tilt wheelchair to prevent rising. In reviewing the resident's clinical record, there was no documentation related to what alternatives were considered and why those alternatives were inappropriate in the progress notes or in the quarterly physical restraint assessments completed in three identified months in 2014. When the registered staff were interviewed they were unable to provide any information related to alternatives that were considered prior to the use of the seat belt and the tilt wheelchair restraints.
The ADRC confirmed staff were expected to consider all feasible alternatives and proven ineffectiveness before a restraint was considered. [s. 110. (7) 2.]

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 physical device is applied in accordance with the manufacturer's instructions and to ensure that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances and to ensure that the documentation includes what alternatives are considered and why those alternatives are inappropriate, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

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

On February 23, 2015 a medication cart was observed to be parked in the hallway by the dining room on the main floor unattended and unlocked. The medication cart was unattended and unlocked for 2 minutes. The registered staff member returned to the dining room and reported that they went to the nursing station for a minute to deal with an issue as the computer was not working. The registered staff confirmed that it is an expectation that the medication cart is locked at all times when unattended. The registered staff did not ensure that the medication cart was locked when not in use. [s. 129. (1) (a) (ii)]

Additional Required Actions:

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

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to minimize restraining of residents was complied with.

The home's policies called "Least Restraints - Use and Application", number 30-06-03A, reviewed February 5, 2013, and "Least Restraints - Alternatives to Using", number 30-06 -03C, reviewed February 10, 2013 identifies the decision making process prior to the initiation of a restraint; the process for applying the prescribed restraint; the documentation requirements; monitoring requirements; the evaluation of the restraint used on a resident; and the ongoing requirements for the use of a restraint. Resident #022 had no consent for the tilt wheelchair restraint; there was no documentation of alternatives that were tried and proven ineffective, or the length of time the restraint will be used; staff were not knowledgeable on the correct and safe application of the seat belt restraint according to the manufacturer's specifications; there was no monitoring record initiated for the tilt wheelchair restraint; and the resident's care plan was not revised to reflect the use of the tilt wheelchair restraint and interventions required. The registered staff, PSWs and the ADRC confirmed they were not in compliance with the home's policies and procedures. [s. 29. (1) (b)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

In reviewing the home's policies and procedures and documentation related to the Continence Care Program, the LTC Inspector was unable to find an annual program evaluation. When interviewing the DRC, they confirmed that they could not find their annual program evaluation for 2013, and the 2014 annual evaluation was not completed. The home was unable to provide any documentation to support that the Continence Care Program has been evaluated and updated at least annually in accordance with evidence-based practices, or in accordance with prevailing practices. There was no written record relating to the evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 3.]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle was reviewed by the Residents' Council.

On February 11, 2015, the Dietary Manager confirmed that the menu cycles are reviewed with the Dining Room Committee, not the Residents' Council. The Dietary Manager then stated the minutes are given to the Activation Manager to review with the Residents' Council. The Activation Manager and the president of the Residents' Council, confirmed on February 11, 2015, that a review of the menu cycle had not been done with the Residents' Council. [s. 71. (1) (f)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the dining and snack services included a review of the meal and snack times by the Residents' Council.

On February 11, 2015 the president of the Residents' Council, and the Dietary Manager confirmed that a review had not been done with the Residents' Council, of the meal and snack times. This was also confirmed in the review of the 2014 Residents' Council Minutes. [s. 73. (1) 2.]

Issued on this 4th day of August, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561), CATHIE ROBITAILLE (536), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2015_301561_0004
Log No. / Registre no:	H-001939-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 5, 2015
Licensee / Titulaire de permis :	HOLLAND CHRISTIAN HOMES INC 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	FAITH MANOR NURSING HOME 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To HOLLAND CHRISTIAN HOMES INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_207147_0006, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
   i. a physician,
   ii. a registered nurse,
   iii. a registered practical nurse,
   iv. a member of the College of Occupational Therapists of Ontario,
   v. a member of the College of Physiotherapists of Ontario, or
   vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure all residents area assessed for the use of a PASD to assist in routine activities of daily living, alternatives to the use of the PASD has been considered, the use of PASD was reasonable given the resident's condition, consent had been obtained and the device was approved.

The compliance plan is to be emailed to Daria Trzos - Nursing Inspector at Daria.Trzos@ontario.ca by June 30, 2015.

Grounds / Motifs :

1. An order was previously issued for this non-compliance in April 2014 with a compliance date of April 30, 2014.

The home had submitted a plan of action to the Ministry of Health and Long-Term Care in April, 2014 that included short term and long term actions. In the plan the home had identified that the immediate action the home undertook was further development of the PASD package and alterations to policy to meet the legislation requirement. The PASD package was to contain assessment, use of alternatives, consent and evaluation of PASD. The plan also indicated that this package was already posted and staff were instructed on the implementation and use of the PASD.

Health records of three residents were reviewed on February 18, 2015 and indicated the following:

i) Resident #035 used one side rail up when in bed as a PASD for comfort and to assist with bed mobility as needed.
ii) Resident #040 used two upper half rails when in bed as a PASD for comfort and to assist with bed mobility.
iii) Resident #100 used one side rail up when in bed as a PASD for comfort and to assist with bed mobility.

Interview with registered staff indicated that there were no assessments completed and alternatives to the use of PASDs were not considered prior to the application of the PASD for the three residents. The health care records did not include the approval of the PASD by an appropriate person as defined in the legislation nor was consent documented as being obtained from the resident for the use of the PASD.

The registered staff members that were interviewed were not aware of legislative requirements related to PASDs. Interview with the Director of Resident Care (DRC) confirmed that the PASD package as identified on the action plan was still in the development stages and was not in use. The DRC also confirmed that the requirements for the use of PASDs as specified in the legislation were not completed for the residents identified.

(561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_207147_0006, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall:
1. Re-assess all bed system to determine if they passed zones of entrapment 1-4. Refer to Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".
2. Implement a system to keep track of all beds in the home, what size of bed rails are used, all the zones that were tested, whether they failed or passed, date of the audit that was completed and by whom,
3. Where bed systems have failed zones of entrapment 1-4, the home shall mitigate immediately any entrapment risks to residents
4. Develop a comprehensive bed safety assessment tool using as a guide the US Federal Food and Drug Administration document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
5. An interdisciplinary assessment of all residents using the bed safety assessment tool shall be completed and the results and recommendations of the assessment shall be documented.
6. The home shall continue to re-assess the bed system and complete the comprehensive bed safety assessment when there is a change in resident's condition, when a new resident is admitted to the home and when any parts of the bed systems are changed
7. Update all resident care plans to include whether bed rails are used, how many, which side of the bed and the reason. Include the use of any interventions, such as bed accessories if the bed has not passed all entrapment zones.
8. Educate all staff that provide direct care to residents on bed safety, bed rail use and entrapment zones.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

An order was previously issued for this non-compliance with the compliance date of October 31, 2014. An immediate order dated March 14, 2014 was also issued for not ensuring that steps were taken to minimize the risk for all entrapment zones for beds: F204-1, F207-B and F125-A.

The home had submitted an action plan to the Ministry for Health and Long Term Care in April, 2014 identifying the short and long term actions in order to meet the legislative requirements.

The short term action identified by the home was to complete the audit by May 2014 of all beds in the home and assess the use of all bed rails to ensure resident safety.
The long term action was to establish a detailed plan to track all risks/potential risks and fix or replace any entrapment safety issues. The plan to fix or replace all beds was to be completed by October 2014. There was no indication that the home had rectified all the beds that failed the zones of entrapment in 2014.

A) The record review and the interview with the Director of Resident Care (DRC) on February 18, 2015, indicated that the bed entrapment zone audit was completed in June 2014 by the DRC. The results of the audit concluded that 47% of the beds failed one or more zones of entrapment which could potentially cause injury to the resident. The audit sheet did not indicate which zones had failed. The DRC had completed another audit on January 16, 2015 and February 13, 2015. The audit sheet indicated that out of 120 beds in the home only 16 passed the entrapment risk assessment for zones. The DRC confirmed that a number of new beds and 8 new mattresses were ordered but not yet received.

B) During stage 1 of the Resident Quality Inspection (RQI) and during the tour of the home in February 2015, there was a number of beds that had gaps between head boards and mattresses, between the top and bottom bed rails and between bed rails and mattresses. Some beds were furnished with quarter length assist bed rails and others with older full length rails. Some of the headboards and rails were wiggling and others had no mattress keepers to keep the mattresses from sliding.

C) At the time of this inspection, the home removed some of the bed rails from residents' beds that did not require bed rails. The DRC reported that the home did not have a system in place to determine which residents required bed rails and that the staff were applying the bed rails for residents that did not require them.

D) On February 19, 2015, the Maintenance Manager and Maintenance

Supervisor confirmed that the home did not have a policy in place for bed rails and entrapment zones prior to the RQI that commenced on February 5, 2015. The "Entrapment – Bed Rails" policy was developed and implemented in the home on February 13, 2015.

The home did not ensure that all residents were assessed, their bed systems were evaluated to minimize risk to residents and steps were taken to prevent resident entrapment taking into consideration all potential zones of entrapment after the order was issued to the home in March 2014. (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2014_207147_0006, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff who provide direct care to the residents are trained on the following:

- requirements set out in the legislation in relation to the the use of PASDs, training in the application of PASDs, monitoring residents with PASDs, use and potential dangers of the PASDs,
- continence care and bowel management,
- minimizing of restraining

The plan is to be emailed to Daria Trzos - Nursing Inspector at Daria.Trzos@ontario.ca by June 30, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that training related to continence care and bowel management to all staff who provide direct care to residents on either an

annual basis, or based on the staff's assessed training needs.

Review of the plan of care for resident #042 and #007 was unable to determine when the residents' were assessed for continence and what strategies were implemented based on the assessments. Interview with the registered staff confirmed they were unsure of what assessment tool designed for continence care was utilized in the home. The staff were also unsure of their home's policy and procedures, and when they were last trained in continence care. When the DRC was interviewed, who is also the lead for the Continence Care Program, stated that many of the elements of the Continence Care Program were not implemented and was a work in progress. The DRC identified that the number of direct care providers trained in the Continence Care Program was low. The Education and Human Resources Coordinator confirmed that there was 49.2 percent of PSWs trained in continence care; 31.6 percent RPNs trained in continence care; and 50 percent RNs trained in continence care. Overall the percentage of direct care providers in the home trained in 2014 in continence care was 43.6 percent. (527)

2. The licensee has failed to ensure that all staff who apply physical devices or who monitor residents restrained by a physical device, including: application of these physical devices; use of these physical devices, and potential dangers of these physical devices were trained

On two identified dates in February 2015, resident #022 was observed to have a loose seat belt and the resident was unable to undo the seat belt. When interviewing the PSWs and registered staff they were unsure of the correct application of the seat belt for resident #022; they did not know what the manufacturer's instructions were for the application of the seat belt and the use of the tilt wheelchair; they did not identify that the resident had a tilt wheelchair restraint; they were not familiar with the home's policies and procedures for Least Restraints; and they were not able to identify the potential dangers of the restraints used for this resident. When reviewing the staff training for Minimization of Restraints for 2014 it was identified that only 52% of staff were trained. Not all the registered staff and PSWs could confirm they had received training in this past year. The ADRC confirmed that not all staff who apply physical devices, or who monitor residents restrained by a physical device were trained in 2014. (527)

3. The licensee failed to ensure that training was provided to all staff who

provided direct care to residents, including training for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

A previous order was issued for this non-compliance in relation to training for staff who apply PASDs.

The home had submitted an action plan to the Ministry of Health and Long Term Care in April 2014. The action plan indicated that the Nursing Staff including registered staff and PSWs will have mandatory PASD education through Surge Learning to be completed within 30 days.

The home's training records and the ADRC confirmed that only 52% of direct care providers received training in the application, use and potential dangers of the PASDs in the year 2014. The interview with registered staff members indicated that they were not aware of the requirements for PASDs as specified in the legislation.
(561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to the Ministry of Health and Long Term Care that outlines how the structure will be changed to ensure that on site Administrator hours are provided to the home as required by the legislation.

The compliance plan is to be emailed to Daria Trzos - Nursing Inspector at Daria.Trzos@ontario.ca by June 30, 2015.

Grounds / Motifs :

1. The licensee failed to ensure the home's Administrator works regularly in that position on site at the home at least 35 hours per week.

A Written Notification was previously issued for this non-compliance on February 3, 2014.

In the previous non-compliance issued to the home evidence indicated and confirmed by the Management Board chair person and the Executive Director/Administrator that the Administrator of the home holds dual responsibilities for the administration of Faith Manor as well as the overall administration of Holland Christian Homes Incorporated. This dual role would not allow the Administrator to work regularly in the position of Administrator of Faith Manor for a least 35 hours per week. The Executive Director/Administrator confirmed that his role within the corporation includes overall responsibility for two 120 bed Long Term Care Homes and a complex that includes 641 apartments over six buildings many of which have some form of assisted living arrangements including meals on wheels operations.

Interview with the Administrator and the Director of Resident Care on February 23, 2015, confirmed that the Administrator role has not changed since the non-compliance was previously issued. The Administrator also confirmed that the Administrator duties and responsibilities were shared among the DRC and the ADRC who covered part of the 35 hours per week requirement.
(561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that all staff who provide direct care to residents receive training related to abuse recognition and prevention annually, and as a condition of continuing to have contact with residents. The plan shall include, but is not limited to:

1. Completion of an evaluation to determine the effectiveness of the home's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvement are required to prevent further occurrences.
2. Mandatory education for all staff in relation to: abuse recognition, prevention of abuse and neglect, and the home's policy for zero tolerance of abuse and neglect.
3. Review of the home's communication processes related to completion of the mandatory education (human resources department and the nursing department).
4. Quality management activities to ensure staff have completed the required training.

The plan shall be submitted by June 30, 2015 to Long-Term Care Homes Inspector, Michelle Warrener, via email to: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that all staff who provide direct care to resident, received training relating to abuse recognition and prevention annually, and as a condition of continuing to have contact with residents (s. 76(7)).

A) The HR Coordinator and DRC confirmed that 29 PSW/Nursing Aides, 25 RPNs, and 14 RNs, had not completed the training between January 1 - December 31, 2014 (active staff members only).

B) The HR Coordinator and DRC confirmed that direct care staff who had not completed the mandatory training on the prevention of abuse and neglect were not prevented from working with residents.

C) An identified PSW who was involved in an alleged verbal abuse of a resident had not completed the mandatory abuse recognition and prevention training in 2014 and was allowed to continue working with residents. The training was not provided/completed after the alleged incident and the staff member did not have an assessment of their training needs to identify alternative learning needs. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 5th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

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