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

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

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Inspection de soins de longue durée

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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
Feb 8, 2017	2017_539120_0001	014841-16, 025392-16, 025394-16, 025395-16, 025399-16, 025408-16	Follow up

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 4, 5, 6, 2017

An inspection (2016-265526-0010) was previously conducted between April and May 2016. A total of 14 orders were issued related to various resident care issues and their bed safety program.
For this follow-up visit, 5 orders were reviewed for compliance.

003 (025392-16) - related to prevention of abuse and staff training
004 (025394-16) - related to steps taken following abuse investigations
005 (025395-16) - related to resident's council and access to a satisfaction survey
007 (025399-16) - related to bed safety and resident clinical assessments
013 (025408-16) - related to staff training and pain management

Orders #004 and #005 have been complied with, however the remaining three orders remain outstanding. See below for details.

A follow-up inspection (2016-449619-0010) was conducted on March 14, 2016 at which time order #001 related to inadequate administrative hours was issued. For this follow-up inspection, the conditions in the order related to administrative hours has been complied with.

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Director of Resident Care (ADRC), Director of Resident Care (DRC), Environmental Services Manager, Physiotherapist, registered and non-registered staff, residents and families.

During the course of the inspection, the inspector toured both floors, selected a number of random resident rooms and observed the bed systems, reviewed staff training records, resident clinical health records, bed entrapment audit records, resident bed rail use assessments, bed safety policies and procedures, prevention of resident abuse policies and procedures and administrative investigative notes related to allegations of resident abuse.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 VPC(s)**
- **3 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
O.Reg 79/10 s. 212. (1)	CO #001	2016_449619_0010	120
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #004	2016_265526_0010	120
LTCHA, 2007 S.O. 2007, c.8 s. 85. (3)	CO #005	2016_265526_0010	120

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

An inspection was previously conducted between April and May 2016 and as a result, non-compliance was identified with this section. An order was issued to redevelop the home's existing clinical assessment form related to bed rails in accordance with prevailing practices and to re-assess all residents using the redeveloped form by an interdisciplinary team.

Resident Assessments

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

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

For this follow up inspection, five residents (#101, 103, 105, 107, 108) were selected for review to determine if each resident using a bed rail was assessed in accordance with the above noted Clinical Guidance document which was also outlined in the order issued on July 19, 2016. The licensee's clinical bed rail use assessment process and forms were reviewed and determined to be non-compliant.

All five residents reviewed had a written plan of care identifying what type of bed rail, how many and the reasons for their application. Several of the residents were also observed in bed with one or more bed rails applied. All five residents had completed assessments titled “Personal Assistance Service Device Assessment” (PASD) and were, according to registered staff, assessed, either upon admission or quarterly by both registered staff and personal support workers (PSWs) over a 3 day period for use of their bed rails. The PSWs were required to liaise with registered staff with their findings after the observation period and the form completed by registered staff.

According to the licensee's policy titled "Bed Rails” policy NUR-01-02 dated February 5, 2016, a questionnaire was to be completed by the Registered Nurse (RN) titled "Bed System Assessment" (BSA) on their computer system for each resident upon admission if the resident “desired” the use of their bed rails. The RN was directed to further discuss options or alternatives for bed rails with the resident or SDM and the safety risks associated with bed rails. The policy identified that at the conclusion of the BSA, the nurse would "determine, based on the assessment, whether the bed rail was a restraint or a PASD (Personal Assistance Services Device)". No reference was made in the policy regarding whether the resident was observed sleeping, for how long, what factors were evaluated to determine if the resident was safe to use the bed rails, what alternatives were trialled, for how long and whether the alternatives were successful or not and a final conclusion of potential risk and how to ensure that the bed rail was safe for the resident in their assessed condition. The only reference made to bed safety hazards in the policy fell under section (c) directing the RN to discuss with the resident or their SDM the risks associated with the bed rails.

The "Bed System Assessment" (BSA) was not completed for any of the selected residents. The template to complete the assessment could not be located on the software application identified as “Point Click Care”. According to the Director of Resident Care (DRC), residents were assessed using only the “Personal Assistance Service Device Assessment” form which was developed and designed to determine what type of personal device would assist a resident in their daily activities and not to determine what safety risks were associated with the device or bed rails. The PASD form was limited to identifying what alternatives were trialled before applying the bed rail, however for each resident identified, the bed rail was listed as the “alternative” along with other alternatives identified as “high low bed, pain assessment, verbal instructions, call bell demonstration and Physiotherapist”. No details were provided as to what was trialled before a bed rail was applied, the length of time the alternative was trialled for and the outcome. The list of alternatives did not include additional relevant options found in the Clinical Guidance document such as the use of “perimeter reminders” or “border definers” such as body pillow/cushions/bolsters(soft rails), mattresses with lipped/raised edges, hand grips and various monitoring strategies and distractions (related to insomnia, toileting, pain, behaviours, repositioning, comfort) .These particular accessories or modified equipment were not included as options on the form to better guide staff decision making, however these options were observed to be in use in the home.

The conclusions related to these residents and the use of their bed rails was not

comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

Bed Evaluations

According to the Environmental Services Supervisor (ESS), the bed systems in the home were not part of an on-going monitoring process to ensure that the beds remained free of entrapment hazards in and around the bed rails and no specific policy or procedure had been developed to guide him or his staff in conducting the bed system evaluations. The last bed system evaluations for entrapment zones for most of the beds in the home was completed in June and July 2015. All beds tested passed entrapment zones 1-4 with the exception of four beds which had therapeutic mattresses. Three other beds were noted to have failed zone 5, but when tested during the inspection, the zones passed entrapment. Ten bed systems were evaluated in 2016. The evaluation records for two beds in rooms on the second floor were blank. The ESS reported that new beds were received and some new mattresses received in 2016, however no tracking records were kept related to when new beds were acquired, where they were installed (room number), when and which beds received a new mattress and if they were re-evaluated. The bed frames and mattresses were not marked in any way to ensure that they always remained together after a bed system was measured and determined to have passed all zones of entrapment 1 to 4.

According to Health Canada guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" the frequency of bed system evaluations must be established by liaising with both the bed manufacturer and mattress manufacturers (if ordered separately from the bed manufacturer). Frequency of evaluating both mattresses and bed frames would depend on multiple factors which are identified by the manufacturers' of the products. The home's policy titled "Bed Rails" did not include any information describing what types of bed rail and mattress conditions would warrant a re-evaluation of the bed system and how the beds would all be monitored for these conditions and other safety issues such as latch reliability, sharp edges, hydraulic or electrical failure, overheating of motors, mattress type, rail height from the top of the mattress, use of overlays and bed accessories on an on-going basis. (or more frequently based on manufacturer's instructions), using a specialized tool to measure the space in and around the bed rail and between the bed rail and mattress. Measuring would also be required following any change made to the bed system such as

a different or new bed rail or mattress.

The bed systems in the home were noted to be equipped with the same quarter length bed rails at the head end of the bed and a minimum of four bed systems were noted to have split bed rails, where a set of quarter length bed rails were also attached at the foot end of the bed. During a tour of the home, both in the morning and afternoon, it was observed that the majority of the bed systems when unoccupied, had a minimum of one bed rail in the elevated or raised position, and many covered by bedding. The use of bed rails in the home appeared to be high. [s. 15. (1) (a)]

2. The licensee did not ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

An inspection was previously conducted between April and May 2016 and as a result, non-compliance was identified with this section. An order was issued to ensure that where residents who had been provided with a therapeutic air surface and who required the use of one or more bed rails be provided with appropriate accessories to mitigate any identified safety hazards including entrapment risks.

During this follow up visit, the home's bed safety policies were reviewed. According to the home's "Bed Rails" policy NUR-01-02 dated February 5, 2016, "if a resident is using a therapeutic air mattress or the bed fails the entrapment test, and the resident requires the use of bed rails, appropriate accessories will be used to mitigate any risk for bed entrapment. Accessories may include body pillows, pool noodles, rolled blankets, gap fillers etc." Several residents were observed in bed, with a therapeutic mattress on their bed frames and one or more bed rails elevated (in use) at the time of inspection. One identified resident had a written plan of care which identified the use of a therapeutic mattress, two bumper pads for safety and two upper bed rails for bed mobility. However no accessories to mitigate potential bed entrapment zones were observed in use. Another identified resident was observed on a therapeutic mattress with two pillows on either side and had a written plan of care requiring the application of two pillows for comfort, two bed rails for turning and repositioning and no information about any bed accessories necessary to mitigate potential bed entrapment zones when bed rails were in use.

No information was available about the entrapment status of either of the resident's beds, but was presumed to have failed zones 2-4 due to the compressible nature of the mattress. According to HC Guidelines, these mattresses, unless comprised of rigid

perimeter re-enforcement, cannot be measured. As such, residents in these beds must be provided with accessories to mitigate the gaps that may be present when a resident is in bed. Accessories observed to be in use on some resident bed rails identified as bed rail pads were overly large and not form fitting to the size of the bed rail.

Each resident in a specified bedroom on the second floor had a written plan of care requiring that at least two bed rails be applied while in bed for bed mobility. The entrapment status was unknown for both beds and confirmation could not be provided whether any changes were made to the beds. As such, the bed rails should not have been applied until the entrapment status of the bed was known. The potential risk was therefore not mitigated.

Preventative steps were therefore not taken to mitigate potential zones of entrapment for the residents identified. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
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).
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).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provided direct care to residents received training related to pain management, including pain recognition of specific and non-specific signs of pain as required under paragraph 6 of subsection 76(6) of the Act.

As per paragraph 6 of subsection 76(6) of the Act, training must be provided annually unless the the licensee assessed the individual training needs of staff members and those staff members received training based on their assessed needs.

An inspection was previously conducted between April and May 2016 and as a result, non-compliance was identified with this section. An order was issued requiring the licensee to ensure that all direct care staff receive training related to pain management, including pain recognition of specific and non-specific signs of pain.

According to training records provided by the Human Resources Manager, Director of Resident Care and Associate Director of Resident Care, four separate in-services related to pain management were offered, but not to to all direct care staff. Direct care staff includes both registered and non-registered staff (Personal Support Workers PSW). On April 18, 2016, a total of 17 registered and non-registered staff attended, on June 17, 2016, seven registered staff attended, on July 15, 2016, 14 PSWs attended and on September 9, 2016 four registered staff attended. According to the Human Resources Manager, there were approximately 103 direct care staff employed in the home in 2016. An assessment of individual training needs of all direct care staff was not conducted in 2016 related to main management. The licensee was therefore required to ensure that each staff member who provided direct care received training related to pain management, including pain recognition of specific and non-specific signs of pain in 2016. [s. 221. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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 did not ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and did not ensure that the policy was complied with.

An inspection was previously conducted between April and May 2016 and as a result, non-compliance was identified with this section. An order was issued to conduct "face to face" retraining of all staff regarding; when to report any witnessed, suspected or alleged abuse to the charge nurse or Director of Resident Care; the definitions of abuse; and the employee's responsibility if they observed or learned of abuse against a resident. During this follow up visit, confirmation was made with the Administrator that not all staff attended "face to face" training in 2016.

Staff training which included "in-class" or a "live event" included "Prevention of Abuse and Neglect + Abuse Definitions and the Abuse Tree" given by an Associate Director of Resident Care on April 20, 2016. It was attended by 15 registered staff. The details of the in-service were not available.The second in-service provided included "Abuse in Long Term Care" given by a physician on August 26, 2016. It was attended by 33 staff from the nursing department. The details of the in-service were not available. The third in-service included "Elder Abuse Awareness" presented by a Police Officer from Peel Region and attended by 47 staff (from various departments) on September 13, 2016. The details of the in-service were not available. The licensee was not able to confirm if all 103 direct care staff (registered and non-registered), including other staff members from different departments such as dietary, housekeeping, maintenance, activities and laundry in the home received at least one "face to face" in-service related to when to report any witnessed, suspected or alleged abuse to the charge nurse or Director of Resident Care; the definitions of abuse; and the employee's responsibility if they observed or learned of abuse against a resident.

The Administrator reported that the home's policies to promote zero tolerance of abuse and neglect of residents were revised in December 2016, just after the Administrator was hired. Mandatory staff training regarding these policies would follow for all staff between February and April 2017. [s. 20. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident-staff communication and response system was easily accessed by residents at all times.

On January 6, 2017, at approximately 1:40 p.m. resident #106, who was not able to get up from their bed independently, was heard to be yelling for assistance from their bedroom by the inspector. The inspector opened the resident's bedroom door at which time the resident eagerly requested that they needed assistance to use the washroom. The inspector found the pull cord, which was attached to the activation station located on a wall to the right of the resident's bed approximately six feet away from the resident's bed and not accessible to the resident. The inspector pulled the activation station for the resident and placed the pull cord on the resident's bed, next to the resident. Several PSWs were asked if the resident was aware of how to use their activation station and they confirmed that the resident did know how to use it. The PSWs were informed that the resident did not have access to the pull cord leading to the station at which time one PSW responded that they recalled putting it on the resident's bed earlier that day.

The licensee did not ensure that the resident-staff communication and response system was easily accessed by resident #106 at all times. [s. 17. (1) (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 the resident-staff communication and response system is easily accessed by residents at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee did not ensure that equipment and devices were readily available at the

home to meet the nursing and personal care needs of residents.

During a tour of the home on January 4 and 5, 2017, a limited number of slings, an essential component of portable and ceiling lift equipment, were made readily available in the home. A total of 14 slings were observed, nine on top of each individual portable lift (sit to stand or full mechanical) and four in clean linen rooms. A selection of different sizes was not available, especially size small. All but one sling was a size medium. No date tags (date of inspection or when placed into circulation) were observed on seven of the slings. One sling was in poor condition and pulled from service by the inspector. The slings were from four different manufacturers and were identified either as a hammock sling, gait belt, toileting sling or combi sling. It was difficult to determine whether they were appropriate for the lifts available in the home.

Personal support workers (PSW) reported shortages of slings and as such used the same slings (those with loops) on the ceiling lifts and on portable floor lifts. Slings were not separately provided in the tub room for residents during bathing. On some days, staff reported having to wait longer to transfer residents due to inappropriate sling type availability. When asked if an extra supply of slings was available, the Director of Resident Care stated that some were available, however they were not shown to the inspector when requested.

According to an inspection report completed by an external contracted service titled "Sling Condition Inspection Report" dated November 23, 2016, only 11 slings were available in the home. Three slings failed for condition and integrity and were pulled from service. Six new slings were ordered and delivered on December 14, 2016. Therefore eight slings were available for use between November 23 and December 14, 2016 for nine mechanical lifts and numerous ceiling lifts.

According to one registered staff member, residents were assessed for sling size by registered staff, however no instructions were available to staff to determine if they were using appropriate methods to determine size and style. No information was available to PSWs regarding the type or size of sling to be used on various residents while using either the portable floor lift or the ceiling lift.

Residents #101, #102 and #103 did not have an assessment to determine what type of sling and what size of sling was appropriate for their individual needs. Residents #101 and #103 required that staff use a mechanical lift to transfer them from one surface to another. Logos indicating such were posted in the their rooms and each stated the

words "total mechanical lift" on the logo with no information about the sling type or size. For each of the three residents, no information was included in their written plan of care regarding sling type or size or specific type of lift to be used. For each of these residents, a PSW reported that they had also used a ceiling lift to transfer the resident. One PSW stated she used the sling in the resident's room and that most resident's had their own sling. However, none of the three residents reviewed had a sling in their room.

Adequate slings for the specific lifts, in adequate numbers and sizes were not readily available in the home to meet the nursing and personal care needs of residents. [s. 44.]

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 equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #6: 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,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee did not ensure that each resident who was incontinent received an assessment that included identification of casual factors and patterns of incontinence and potential to restore function with specific interventions.

As of mid 2016, following a return from hospital following an injury, an identified resident could not independently use the toilet and required staff assistance to maintain both bowel and bladder continence. Prior to the injury, the resident was continent of both bowel and bladder and independently used the toilet. According to progress notes written by registered staff between mid 2016 and early 2017, the resident frequently requested assistance to use the toilet. When out of their room, on several occasions, the resident was not able to maintain continence. On more than three separate occasions, the resident was found on the floor either in the bathroom, or in their bedroom attempting to get to the bathroom. The resident was identified to have two separate episodes of urinary tract infections between mid 2016 and early, 2017.

Urinary and Bowel Continence Assessments were completed for the resident, twice in 2016 and once in 2017. All three assessments were identically completed by three different individuals. Two out of the three assessments included information that the resident was both continent and incontinent for bladder with "urge" incontinence (need to go frequently) and "functional" incontinence, needing assistance to get to the toilet and one assessment (January 2017) identified the resident as both continent and incontinent of bowel. No bowel pattern was identified in any of the three assessments. No voiding diary results were included in any of the assessments. No casual factors were identified for the resident's urinary urgency or frequency and no interventions were identified in restoring bladder function with specific interventions. The conclusion written by all three evaluators was "monitor bladder pattern closely for changes and update care plan accordingly".

The licensee did not ensure that the identified resident who was incontinent received an assessment that included identification of casual factors and patterns of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

2. The licensee did not ensure that the resident, who was unable to toilet independently received assistance from staff to manage and maintain continence.

On a specified date in January, 2017, an identified resident asked the inspector for

assistance to be escorted to their bathroom to use the toilet as they were unable to toilet independently. The inspector pulled the resident's activation station to alert staff that assistance was required. Two minutes later, a staff member entered the resident's room, turned off the alert and left the room, without attending to the resident despite the fact that the resident was requesting toileting assistance. The PSW was observed to walk past the nurse's station and did not inform any other PSWs that the resident had been requesting to be assisted. After the PSW left the bedroom, the resident continued to ask for for assistance. The inspector informed the resident to wait and a different PSW was requested to attend to the resident. The resident requested that they be escorted to the bathroom but the PSW informed the resident that they would receive an alternative intervention.

The resident's progress notes revealed that the resident was previously transferred from their bed to their wheelchair after breakfast. Discussions with several staff who were at the nurse's station also revealed that the resident was in their wheelchair for a short period of time in the morning and had been checked several times for incontinence. The progress notes further revealed that the resident requested to use the bathroom while seated in the wheelchair. The staff did not provide assistance as requested, instead providing an alternative intervention. Discussion with the RN in charge of the unit was held, regarding why the resident was not provided with their requested intervention and they provided a response citing concerns related to the size of the resident's bathroom. The statement however was without merit as the resident could have been assisted by using alternative equipment in the tub/shower room. The Physiotherapist, who had conducted a transfer assessment of the resident in early January 2017 confirmed that the resident could, depending on pain tolerance, be transferred to appropriate equipment to address their needs. Based on progress notes made in early January 2017, the resident was previously transferred using appropriate equipment. The Director of Resident Care confirmed that staff could have transferred the resident to the bathroom in the resident's room or the tub/shower room which provided adequate space for the task.

The identified resident therefore did not receive assistance to manage and maintain continence, initially by having their needs addressed when they requested and secondly, when staff failed to employ the use of appropriate equipment to provide the resident with their requested method of toileting, when tolerated. [s. 51. (2) (c)]

Issued on this 21st day of February, 2017

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2017_539120_0001
Log No. / Registre no:	014841-16, 025392-16, 025394-16, 025395-16, 025399-16, 025408-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 8, 2017
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 :	Tracy Kamino

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_265526_0010, CO #007;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:

1. Amend the home's existing forms related to bed rail use and bed safety assessments or create a new form to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006". The amended questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period; and

c. the resident while sleeping for a specific period of time to establish risks to the resident after a bed rail has been applied and deemed necessary where an alternative was not successful; and

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form and document the assessed results and recommendations for each resident.

3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories that are required to mitigate any identified bed safety hazards.

4. Amend the existing policy and procedure titled "Bed Rails" so that it will guide an assessor in completing resident clinical bed safety assessments in accordance with the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" and implement the policy.

5. Develop a policy and procedure that will guide an assessor in completing bed system evaluations in accordance with Health Canada Guidelines titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006” and implement the policy.

Grounds / Motifs :

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

An inspection was previously conducted between April and May 2016 and as a result, non-compliance was identified with this section. An order was issued to redevelop the home's existing clinical assessment form related to bed rails in accordance with prevailing practices and to re-assess all residents using the redeveloped form by an interdisciplinary team.

Resident Assessments

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance

Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

For this follow up inspection, five residents (#101, 103, 105, 107, 108) were

selected for review to determine if each resident using a bed rail was assessed in accordance with the above noted Clinical Guidance document which was also outlined in the order issued on July 19, 2016. The licensee's clinical bed rail use assessment process and forms were reviewed and determined to be non-compliant.

All five residents reviewed had a written plan of care identifying what type of bed rail, how many and the reasons for their application. Several of the residents were also observed in bed with one or more bed rails applied. All five residents had completed assessments titled “Personal Assistance Service Device Assessment” (PASD) and were, according to registered staff, assessed, either upon admission or quarterly by both registered staff and personal support workers (PSWs) over a 3 day period for use of their bed rails. The PSWs were required to liaise with registered staff with their findings after the observation period and the form completed by registered staff.

According to the licensee's policy titled "Bed Rails” policy NUR-01-02 dated February 5, 2016, a questionnaire was to be completed by the Registered Nurse (RN) titled "Bed System Assessment" (BSA) on their computer system for each resident upon admission if the resident “desired” the use of their bed rails. The RN was directed to further discuss options or alternatives for bed rails with the resident or SDM and the safety risks associated with bed rails. The policy identified that at the conclusion of the BSA, the nurse would "determine, based on the assessment, whether the bed rail was a restraint or a PASD (Personal Assistance Services Device)”. No reference was made in the policy regarding whether the resident was observed sleeping, for how long, what factors were evaluated to determine if the resident was safe to use the bed rails, what alternatives were trialled, for how long and whether the alternatives were successful or not and a final conclusion of potential risk and how to ensure that the bed rail was safe for the resident in their assessed condition. The only reference made to bed safety hazards in the policy fell under section (c) directing the RN to discuss with the resident or their SDM the risks associated with the bed rails.

The "Bed System Assessment" (BSA) was not completed for any of the selected residents. The template to complete the assessment could not be located on the software application identified as “Point Click Care”. According to the DRC, residents were assessed using only the “Personal Assistance Service Device Assessment” form which was developed and designed to determine what type of

personal device would assist a resident in their daily activities and not to determine what safety risks were associated with the device or bed rails. The PASD form was limited to identifying what alternatives were trialled before applying the bed rail, however for each resident identified, the bed rail was listed as the "alternative" along with other alternatives identified as "high low bed, pain assessment, verbal instructions, call bell demonstration and Physiotherapist". No details were provided as to what was trialled before a bed rail was applied, the length of time the alternative was trialled for and the outcome. The list of alternatives did not include additional relevant options found in the Clinical Guidance document such as the use of "perimeter reminders" or "border definers" such as body pillow/cushions/bolsters(soft rails), mattresses with lipped/raised edges, hand grips and various monitoring strategies and distractions (related to insomnia, toileting, pain, behaviours, repositioning, comfort) .These particular accessories or modified equipment were not included as options on the form to better guide staff decision making, however these options were observed to be in use in the home.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

Bed Evaluations

According to the Environmental Services Supervisor (ESS), the bed systems in the home were not part of an on-going monitoring process to ensure that the beds remained free of entrapment hazards in and around the bed rails and no specific policy or procedure had been developed to guide him or his staff in conducting the bed system evaluations. The last bed system evaluations for entrapment zones for most of the beds in the home was completed in June and July 2015. All beds tested passed entrapment zones 1-4 with the exception of four beds which had therapeutic mattresses. Three other beds were noted to have failed zone 5, but when tested during the inspection, the zones passed entrapment. Ten bed systems were evaluated in 2016. The evaluation records for two beds in rooms on the second floor were blank. The ESS reported that new beds were received and some new mattresses received in 2016, however no tracking records were kept related to when new beds were acquired, where they were installed (room number), when and which beds received a new

mattress and if they were re-evaluated. The bed frames and mattresses were not marked in any way to ensure that they always remained together after a bed system was measured and determined to have passed all zones of entrapment 1 to 4.

According to Health Canada guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" the frequency of bed system evaluations must be established by liaising with both the bed manufacturer and mattress manufacturers (if ordered separately from the bed manufacturer). Frequency of evaluating both mattresses and bed frames would depend on multiple factors which are identified by the manufacturers' of the products. The home's policy titled "Bed Rails" did not include any information describing what types of bed rail and mattress conditions would warrant a re-evaluation of the bed system and how the beds would all be monitored for these conditions and other safety issues such as latch reliability, sharp edges, hydraulic or electrical failure, overheating of motors, mattress type, rail height from the top of the mattress, use of overlays and bed accessories on an on-going basis. (or more frequently based on manufacturer's instructions), using a specialized tool to measure the space in and around the bed rail and between the bed rail and mattress. Measuring would also be required following any change made to the bed system such as a different or new bed rail or mattress.

The bed systems in the home were noted to be equipped with the same quarter length bed rails at the head end of the bed and a minimum of four bed systems were noted to have split bed rails, where a set of quarter length bed rails were also attached at the foot end of the bed. During a tour of the home, both in the morning and afternoon, it was observed that the majority of the bed systems when unoccupied, had a minimum of one bed rail in the elevated or raised position, and many covered by bedding. The use of bed rails in the home appeared to be high. (120)

2. The licensee did not ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

An inspection was previously conducted between April and May 2016 and as a result, non-compliance was identified with this section. An order was issued to ensure that where residents who had been provided with a therapeutic air surface and who required the use of one or more bed rails be provided with

appropriate accessories to mitigate any identified safety hazards including entrapment risks.

During this follow up visit, the home's bed safety policies were reviewed. According to the home's "Bed Rails" policy NUR-01-02 dated February 5, 2016, "if a resident is using a therapeutic air mattress or the bed fails the entrapment test, and the resident requires the use of bed rails, appropriate accessories will be used to mitigate any risk for bed entrapment. Accessories may include body pillows, pool noodles, rolled blankets, gap fillers etc." Several residents were observed in bed, with a therapeutic mattress on their bed frames and one or more bed rails elevated (in use) at the time of inspection. One identified resident had a written plan of care which identified the use of a therapeutic mattress, two bumper pads for safety and two upper bed rails for bed mobility. However no accessories to mitigate potential bed entrapment zones were observed in use. Another identified resident was observed on a therapeutic mattress with two pillows on either side and had a written plan of care requiring the application of two pillows for comfort, two bed rails for turning and repositioning and no information about any bed accessories necessary to mitigate potential bed entrapment zones when bed rails were in use.

No information was available about the entrapment status of either of the resident's beds, but was presumed to have failed zones 2-4 due to the compressible nature of the mattress. According to HC Guidelines, these mattresses, unless comprised of rigid perimeter re-enforcement, cannot be measured. As such, residents in these beds must be provided with accessories to mitigate the gaps that may be present when a resident is in bed. Accessories observed to be in use on some resident bed rails identified as bed rail pads were overly large and not form fitting to the size of the bed rail.

Each resident in a specified bedroom on the second floor had a written plan of care requiring that at least two bed rails be applied while in bed for bed mobility. The entrapment status was unknown for both beds and confirmation could not be provided whether any changes were made to the beds. As such, the bed rails should not have been applied until the entrapment status of the bed was known. The potential risk was therefore not mitigated.

Preventative steps were therefore not taken to mitigate potential zones of entrapment for the residents identified

This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is wide spread (3), where most of the residents have not been assessed according to prevailing practices, the severity of the non-compliance is potential for harm/risk (2) and the history of non-compliance under s. 15(1) of Ontario Regulation 79/10 is (3) previously issued non-compliance under the same section within the the last 3 years. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_265526_0010, CO #013;

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 provide all staff who provide direct care to residents training related to pain management, including pain recognition of specific and non-specific signs of pain;

a) annually, or
b) when individual direct care staff have identified a need for training after completing an assessment to determine if their needs have been met.

Grounds / Motifs :

1. The licensee did not ensure that all staff who provided direct care to residents received training related to pain management, including pain recognition of specific and non-specific signs of pain as required under paragraph 6 of subsection 76(6) of the Act.

As per paragraph 6 of subsection 76(6) of the Act, training must be provided

annually unless the the licensee assessed the individual training needs of staff members and those staff members received training based on their assessed needs.

An inspection was previously conducted between April and May 2016 and as a result, non-compliance was identified with this section. An order was issued requiring the licensee to ensure that all direct care staff receive training related to pain management, including pain recognition of specific and non-specific signs of pain.

According to training records provided by the Human Resources Manager, Director of Resident Care and Associate Director of Resident Care, four separate in-services related to pain management were offered, but not to to all direct care staff. Direct care staff includes both registered and non-registered staff (Personal Support Workers PSW). On April 18, 2016, a total of 17 registered and non-registered staff attended, on June 17, 2016, seven registered staff attended, on July 15, 2016, 14 PSWs attended and on September 9, 2016 four registered staff attended. According to the Human Resources Manager, there were approximately 103 direct care staff employed in the home in 2016. An assessment of individual training needs of all direct care staff was not conducted in 2016 related to main management. The licensee was therefore required to ensure that each staff member who provided direct care received training related to pain management, including pain recognition of specific and non-specific signs of pain in 2016.

This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is pattern (2), where some of the direct care staff have not received training in pain management, the severity of the non-compliance is potential for harm/risk (2) and the history of non-compliance under s. 15(1) of Ontario Regulation 79/10 is on-going (4) with an order issued July 19, 2016.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2016_265526_0010, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall conduct "face to face" training for all staff regarding the home's policy regarding the requirement to "immediately report any witnessed, suspected, or alleged abuse to the charge nurse or Director of Resident Care".

Grounds / Motifs :

1. The licensee did not ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and did not ensure that the policy was complied with.

An inspection was previously conducted between April and May 2016 and as a result, non-compliance was identified with this section. An order was issued to conduct "face to face" retraining of all staff regarding; when to report any witnessed, suspected or alleged abuse to the charge nurse or Director of Resident Care; the definitions of abuse; and the employee's responsibility if they observed or learned of abuse against a resident. During this follow up visit, confirmation was made with the Administrator that not all staff attended "face to face" training in 2016.

Staff training which included "in-class" or a "live event" included "Prevention of Abuse and Neglect + Abuse Definitions and the Abuse Tree" given by an Associate Director of Resident Care on April 20, 2016. It was attended by 15 registered staff. The details of the in-service were not available.The second in-service provided included "Abuse in Long Term Care" given by a physician on

August 26, 2016. It was attended by 33 registered and non-registered staff. The details of the in-service were not available. The third in-service included "Elder Abuse Awareness" presented by a Police Officer from Peel Region and attended by 47 staff (from various departments) on September 13, 2016. The details of the in-service were not available. The licensee was not able to confirm if all 103 direct care staff (registered and non-registered), including other staff members from different departments such as dietary, housekeeping, maintenance, activities and laundry in the home received at least one "face to face" in-service related to when to report any witnessed, suspected or alleged abuse to the charge nurse or Director of Resident Care; the definitions of abuse; and the employee's responsibility if they observed or learned of abuse against a resident.

The Administrator reported that the home's policies to promote zero tolerance of abuse and neglect of residents were revised in December 2016, just after the Administrator was hired. Mandatory staff training regarding these policies would follow for all staff between February and April 2017.

This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is pattern (2), where many of the staff have not received training, the severity of the non-compliance is potential for harm/risk (2) and the history of non-compliance under s. 15(1) of Ontario Regulation 79/10 is on-going (4) with an order issued July 19, 2016.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 8th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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