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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
Dec 22, 2015	2015_332575_0020	029574-15	Resident Quality Inspection

Licensee/Titulaire de permis

LADY DUNN HEALTH CENTRE
17 Government Road Box 179 Wawa ON P0S 1K0

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

LADY DUNN HEALTH CENTRE
17 Government Road P.O. Box 179 Wawa ON P0S 1K0

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

LINDSAY DYRDA (575), LISA MOORE (613)

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): November 16-18 and 21-24, 2015

During the course of the inspection, two additional follow-up logs to four previous compliance orders were inspected.

During the course of the inspection, the inspector(s) spoke with the Co-Chief Executive Officer/Director of Patient Care Services (DOPCS), Long-Term Care Team Leader (TL), Continuous Quality Improvement Coordinator (QI), Nurse Educator (NE), Activity Coordinator (AC), Infection Prevention and Control Team Lead, Maintenance staff (M), Registered Dietitian (RD), Cook/Dietary Server (DS), Resident Council Assistant (RCA), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Family Members, and Residents.

The inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **16 WN(s)**
- **7 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
O.Reg 79/10 s. 229. (2)	CO #002	2015_376594_0014	575
O.Reg 79/10 s. 229. (3)	CO #003	2015_376594_0014	575

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. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents received 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).

On November 23, 2015, Inspector #613 requested the training records and resource training material from the Nurse Educator (NE) on abuse recognition and prevention and minimizing the restraining of residents. The NE informed the inspector that they had not provided the staff any education training in 2015 to date, that no education had occurred for approximately one year, that they had submitted an education plan but had not received approval, and that they were unable to provide education to staff until they received approval.

Inspector #613 asked the NE if training had been provided to staff in regards to the devices used by resident #001 and #008. The NE confirmed that no education had been provided to staff on the use of these devices and that the NE was not aware that these devices were being used. The NE also confirmed that there were no attendance lists or resource training material to demonstrate that education had been provided to staff on abuse recognition & prevention and restraints in the last 12 months.

Inspector #613 interviewed the Director of Patient Care Services (DOPCS) who confirmed that none of the mandatory education training had occurred yet in 2015.

The NE provided the inspector with training records for 2013, 2014 and 2015. In 2013, the records showed 27 out of 31 (87%) staff completed the Annual Review which consisted of reviewing the following policies:
-Residents Bill of Rights
-Home Mission Statement
-Staff Reporting and Whistle Blowing Protection
-Zero Tolerance for Abuse & Neglect
-Minimizing Restraints

In 2014, the training records showed that staff received the same topics for training as in 2013 with the addition of the Client Concerns Handling Program. In 2015, the only training provided to staff was Gentle Persuasive Approaches (GPA). This training was provided April 20, 27, May 4, and June 22, 2015. No other training records, resource material or attendance sheets were available.

The education the home provided to staff in 2013, 2014 and 2015 did not include all of the mandatory annual training as per the Long-Term Care Homes (LTCH) Act and Regulations. Under section 76(7) the following annual training is required:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations.

Under O.Reg 221 (1), for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which annual 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.

In addition, the licensee shall ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours and the training required under paragraph 4 of subsection 76 (7) of the Act includes training in the application, use and potential dangers of physical devices used to restrain residents and personal assistance services devices.

The NE provided the inspector their education plan for 2014 and 2015 which did not include all of the required mandatory annual training as per the LTCH Act and Regulations. The home had not provided all of the required education training as per the LTCH Act and Regulations for the past three years. [s. 221. (2) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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. (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:
6. All assessment, reassessment and monitoring, including the resident’s response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the physical device used to restrain resident #001 was applied in accordance with the manufacturer's instructions.

On November 17 and 18, 2015, Inspector #575 observed resident #001 with a device applied.

Inspector #575 reviewed the resident's plan of care and noted a physician's order for the device as needed (PRN). The inspector requested and was provided the manufacturer's instructions for the device and noted that the instructions stated the following:

-staff must have on going training and be able to demonstrate competency to use the device in accordance with instructions, facility policies and regulations;
-staff should test to make sure that the device is applied properly, as risk of serious injury may occur;

-always use the proper size device.

The inspector noted according to the resident's current weight, the resident would be required to use a certain size device, however, this was not the device currently being used.

The inspector interviewed two RPNs regarding the resident's device. RPN #100 stated that they had not received training on this particular device, that they were not sure how to properly apply it and that sometimes it did not fit properly. RPN #101 indicated that they did not receive training on how to properly apply the device and that they applied the device based on their own judgement. [s. 110. (1) 1.]

2. The licensee has failed to ensure that every use of a physical device used to restrain a resident was documented including all assessment, reassessment and monitoring, including the resident's response.

Inspector #575 reviewed the restraint records for resident #001, #002, and #008 for a period of approximately two months. The restraint record indicated that registered nursing initials were required every eight hours and coded either "N" for necessary or "NR" for no longer required. In addition, the restraint record included the following areas to document: when the restraint was applied, released, visually checked; when the resident was repositioned; the resident's response; the restraint type; the reason for the restraint; and staff initials for who applied the device and completed the monitoring.

The inspector noted the following:

For resident #001 on 40 occasions, the documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances; and on seven occasions, there were periods of time which failed to document any assessment, reassessment or monitoring of the restraint use.

For resident #002 on 41 occasions, the documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances; and on 10 occasions, there were periods of time which failed to document any assessment, reassessment or monitoring of the restraint use.

For resident #008 on 32 occasions, the documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances; and on 2 occasions, there were periods of time which failed to document any assessment, reassessment or monitoring of the restraint use.

During an interview, RPN #101 indicated that staff are to record on the restraint record when the restraint was applied, when the resident was repositioned, whether the resident tolerated the restraint, and what type of restraint was applied. RPN #101 confirmed that registered staff are to sign the restraint record every eight hours to indicate that the restraint was still required.

The inspector reviewed the restraint records with TL #102 who confirmed that the restraint records were not completed as required. [s. 110. (7) 6.]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 are used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based

practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Inspector #575 observed large gaps in the bed rails for three resident's, specifically in zone 1, 6, and 7.

The inspector interviewed the TL #102 regarding the assessments conducted to determine if a resident required the use of bed rails. TL #102 indicated that bed rail assessments were conducted on admission, depending on some of the information from CCAC, safety issues and concerns. Assessments were also conducted quarterly via the MDS assessment, interviews with staff, family and residents. TL #102 was not aware of the Health Canada guidance document regarding assessing the bed system. TL #102 mentioned that there was a case of one resident in the home who started to have bruises on their legs and it was determined that the resident's legs were touching the bed rails and their legs were getting caught on occasion within the space of the bed rails. No assessments on any other resident's bed system had been conducted.

The inspector interviewed the DOPCS regarding bed rail assessments and entrapment. The DOPCS indicated that after the previous Resident Quality (RQI) Inspection in 2014, the home looked into bed entrapment testing and reached out to a third party regarding the required tools and testing, however, they were unable to obtain the required tools for entrapment testing. The DOPCS also indicated that the bed and mattress were bought together as a system, no assessments of the bed system had been conducted, and they were not aware of the Health Canada guidance document.

A memo from the Ministry of Health and Long-Term Care dated August 21, 2012 was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes.

The guidance document indicated the dimensional limit for zone 1 should be 120 mm or 4.75 inches. The guidance document further indicated that to reduce the risk of head entrapment, openings in the bed system should not allow the widest part of a small head to be trapped. Therefore, a head breadth dimension of 120mm was used as the basis for its dimensional limit recommendations. The population at greatest risk is defined as "patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement or who get out of bed and walk unsafely without assistance. These

patients most often have been frail, elderly or confused”.

The inspector observed the resident beds that had large gaps and noted the bed type was Hill Rom. The inspector measured the dimensions for zone 1 for the Hill Rom beds and noted the median of the rail measured 139.7 millimeters (mm) or 5.5 inches and both ends of the bed rail measured 107.95 mm or 4.25 inches. Zone 6 and 7 were both measured at 139.7 mm or 5.5 inches. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's plan of care set out clear directions to staff and others who provide direct care to the resident.

On multiple occasions, Inspector #575 observed resident #001 with multiple devices in use. The inspector interviewed two registered staff regarding one of the devices. RPN #100 stated that it was used during certain times for positioning and RPN #101 stated that the resident did not always require it and it was not always required at certain times.

The inspector reviewed the resident's health care record. The inspector observed a physician's order that indicated the devices to be used. A signed consent and the resident's care plan was observed that indicated the devices to be used, however, the consent and care plan varied from the physician's order.

The inspector determined that the plan of care did not provide clear directions to staff and others who provided direct care to the resident as the physician's order did not specify the purpose of the device, the consent included multiple devices however, part of the consent indicated the use of one device or another (staff were observed using both at the same time), and the care plan indicated different uses for the device. Staff were not consistent with the purpose and use of one of the devices and RPN #100 and #101 indicated that staff were not trained on the proper use of this device and they were not aware of the manufacturer's instructions. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as specified in the plan.

According to resident #007's most recent MDS assessment, the resident required a nutrition intervention. The inspector reviewed the resident's current care plan, located in the resident's health care record which indicated that staff were initiate a certain intervention monthly and another intervention daily and document. The home's policy regarding the interventions indicated the procedure for the interventions and where staff were to document.

The inspector interviewed three registered staff regarding the interventions:

RPN #105 indicated that staff are to initiate one intervention daily and indicated where staff are to document. RPN #105 indicated that the monthly intervention would be documented on the weight sheet. RPN #105 reviewed the weight sheet and confirmed it was not documented.

RPN #112 indicated that staff do not perform the daily intervention for resident #007.

RPN #112 reviewed the weight sheet for documentation regarding the monthly intervention and confirmed it was not documented on the weight sheet and they were not sure where it would be documented.

TL #102 confirmed to the inspector that staff had not been documenting the daily intervention for resident #007, and confirmed that it should be done daily. TL #102 confirmed that the monthly intervention should be recorded monthly in the nurses notes and that there was nothing documented.

The inspector reviewed the documentation of the daily intervention for a period of approximately 10 days and noted the intervention was only documented on one occasion. The inspector reviewed the nurses notes for a period of approximately six months and the weight sheets for a period of 11 months and there was no documentation of the monthly intervention. [s. 6. (7)]

3. The licensee has failed to ensure that resident #001's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During an interview, resident #001 indicated that staff only assisted them with oral care at night. The inspector interviewed two registered staff (RPN #101 and RPN #113) regarding the resident's oral hygiene routine. RPN #101 and RPN #113 indicated that the resident required assistance with set up, was able to perform their own oral hygiene, required supervision, and oral care was performed twice per day (morning and night).

The inspector reviewed the resident's care plan and noted the following interventions related to oral care:

1.) The resident required the assistance of one staff for oral care twice daily and as needed; and

2.) Staff are to assist with dental/oral care after meals, at bedtime, and as needed. Staff are to allow the resident to attempt to do their own oral care with supervision and assist if needed. Assess for any bleeding or sores in the oral cavity. Report to charge nurse or doctor if any problems.

During an interview, TL #102 indicated that the first intervention should have been removed from the care plan as it was no longer necessary and the second intervention is

the current intervention. [s. 6. (10) (b)]

4. The licensee has failed to ensure that resident #001's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

According to the most recent MDS assessment, resident #001 was incontinent of bladder, usually continent of bowels, and required the use of pads or briefs. During an interview, RPN #101 indicated that the resident was incontinent of bladder and bowels, the resident was unaware when they were incontinent, and the resident wears a medium brief during the day and a large brief during the night. RPN #101 stated that the resident was only toileted when they were being washed, otherwise, the staff assisted the resident with brief changes in the morning, after lunch, before dinner, and before bed.

The inspector reviewed the resident's most recent care plan. Interventions in the care plan indicated that staff were to take the resident to the bathroom when they asked, before breakfast, after lunch and before bed and that they required large briefs during the night and pull-ups during the day.

The care plan was reviewed with RPN #101 who stated that the care plan was not current and that the resident no longer wore pull-ups. During an interview, TL #102 also confirmed that the care plan was not revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 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 ensuring that the care set out in the plan of care is provided to residents as specified in the plan and that the residents plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that recreation and social activities program included the development and implementation of a schedule of recreation and social activities that were offered during evenings and weekends.

Inspector #613 reviewed the home's activity calendars for October, November and December 2015. All three calendars identified only one evening activity, a birthday celebration, occurring in each month. There were no weekend activities identified on the October and November calendars. The December calendar identified one weekend, a decorating party, to occur.

The inspector met interviewed the Activity Coordinator (AC) #103 who informed the inspector that they are attempting to develop an evening program. AC #103 stated that weekend activities only occur occasionally for special events. AC #103 relayed that it was difficult to develop evening and weekend activities due to lack of interested volunteers.

During an interview with the DOPCS it was confirmed that activities do not occur on the evenings or weekends. [s. 65. (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 ensuring that the recreation and social activities program includes the development and implementation of a schedule of activities that are offered during evenings and weekends, to be implemented voluntarily.

WN #6: 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,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle included alternative choices of vegetables and desserts at lunch and dinner.

Throughout the inspection, Inspector #613 observed that residents were not offered choices of vegetables and desserts at lunch or dinner meals. Staff would offer the residents a choice with the main entree, but the same type of vegetable would be served with each entree. It was also noted that staff would offer the residents only one choice of dessert at lunch and dinner meals.

On November 16, 2015 during the dinner meal, all residents were provided with mixed vegetables on their dinner plates and they were only offered a peanut butter cookie for dessert.

On November 25, 2015 during the lunch meal, residents were not offered a choice of vegetables or dessert. Residents who chose the turkey a la king entree had peas with their meal and residents who had a ham salad sandwich only received a sandwich. The dessert provided to the residents was a piece of loaf and no other choice was provided.

The inspector observed that the daily posted menu only listed "vegetables" as being served, it did not identify the types of vegetables and only identified one dessert as being served. The vegetable and dessert choices were not posted on the daily menu to notify the residents, nor were they offered a choice during lunch and dinner meal service. [s. 71. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home's menu cycle includes alternative choices of vegetables and desserts at lunch and dinner, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

**s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that meal substitutions were communicated to residents and staff.

On November 16, 2015, Inspector #613 observed the dinner meal service and noted residents did not receive the meal that was posted on the weekly and daily menu. The weekly menu identified that residents were to receive roasted sweet potatoes, red pepper and broccoli, peanut butter cookie or fruit cocktail with their entree. The daily menu identified salmon or veal, potatoes, vegetables and cookie as the dinner meal. The inspector observed that the residents received mixed vegetables consisting of peas, carrots and corn and mashed white potatoes with their choice of entree. For dessert, the residents received a peanut butter cookie, no other choice was provided. The daily posted menu did not identify the substitutions being served to the residents.

Inspector #613 met with the Cook/Dietary Server (DS) #115 to determine why the dinner meal posted was not served to the residents. DS #115 confirmed that the daily posted menu did not inform the residents of the meal being served and that the substitutions should have been written on the daily posted menu. DS #115 identified that the Cook usually made the decision to make meal substitutions and were to write the substitutions on the daily posted menu, however, on this day they did not.

The inspector interviewed the DOPCS who confirmed that it is the home's expectation to confirm with the Registered Dietitian or the Building Service Manger for approval with meal substitutions. Once the substitution is approved, dietary staff are to write the meal substitution on the daily menu board. The DOPCS confirmed that this was not always done. [s. 72. (2) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that meal substitutions are communicated to residents and staff, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations.

Inspector #613 reviewed the home's policy to promote zero tolerance of abuse and neglect of residents. The inspector noted that the policy did not included the training and retraining requirements for all staff on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, as well as situations that may lead to abuse and neglect, and how to avoid such situations.

During an interview, the DOPCS confirmed that this was not part of the policy, nor was this part of the annual education for staff. [s. 96. (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home's policy to promote zero tolerance of abuse and neglect identifies the training and retraining requirements for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to minimize the restraining of residents included restraining under the common law duty when immediate action is necessary to prevent serious bodily harm to the person or others.

Inspector #575 reviewed the home's policy titled Least Restraints, last reviewed March 30, 2015. On page 9 and 10, under "use of restraints in situations of imminent risk", the policy stated that "in situations where immediate action is required to prevent serious bodily harm to a resident or to another person, where alternatives have been considered and found to be ineffective, and where it is not possible to obtain an order from a physician, a registered nurse may apply a restraint to a resident without consent on an

interim basis". The policy further stated "the rationale for the use of the restraint, including the list of alternatives to the use of restraints that were considered or tried, and the reasons that the alternatives were found to be ineffective, shall be documented by the registered nurse authorizing the use of the restraint. The physician's order shall be obtained within 12 hours of the restraint's application". The policy also directed staff to review the "Least Restraint Decision Tree", appendix I for the use of restraints. This decision tree did not outline the appropriate steps for staff to take when restraining a resident under common law duty.

This policy did not accurately reflect the requirements under the Long-Term Care Home's Act (LTCHA) section 110. (3), that explains the requirements of the licensee when a resident is being restrained by a physical device pursuant to common law duty described in section 36 of the Act. In addition, the policy did not outline the requirements under section 110. (8), regarding what needed to be documented when a resident was restrained under common law duty. This policy did not outline clear directions to staff. [s. 109. (c)]

2. The licensee has failed to ensure that the home's policy to minimize the restraining of residents included the types of physical devices permitted to be used.

On multiple occasions throughout the inspection, Inspector #575 observed resident #001 with a device in use. The resident's plan of care indicated that the device was used as needed. Additionally, on each day of the inspection, Inspector #613 observed resident #008 with a device in use. The resident's plan of care identified that the device was used when the resident was in their wheelchair.

Inspector #575 reviewed the home's policy titled Least Restraints, last reviewed March 30, 2015. The policy indicated that physical restraints included, but were not limited to:
-geriatric chairs or wheelchairs with tabletops in place;
-full bed rails on both side of the bed;
-lap belts that the person is unable to unfasten due to physical or cognitive limitations.

The policy did not outline the devices used by resident #001 or #008 as a physical devices permitted to be used. [s. 109. (d)]

3. The licensee has failed to ensure that the home's policy to minimize the restraining of residents addressed how consent to use a physical device to restrain a resident is to be obtained and documented.

Inspector #575 reviewed the home's policy titled Least Restraints, last reviewed March 30, 2015. On page 9 and 10, under "Restraints", the policy indicated that consent is required for the use of restraints and that "the informed consent for the use of restraints when there is imminent risk of harm to a resident, patient or others shall be obtained within 24 hours of applying the consent".

This is not consistent with the requirements pursuant to the LTCHA section 31. (4) and section 31. (5) whereby the restraining of a resident by a physical device may be included in the resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has approved the restraining, and 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. [s. 109. (e)]

4. The licensee has failed to ensure that the home's policy to minimize the restraining of residents addressed alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach.

Inspector #575 reviewed the home's policy titled Least Restraints, last reviewed March 30, 2015. On page 5, the policy indicated that there were interventions to reduce escalating behaviours that must be individually tailored and documented in the resident's care plan in order to minimize the use of restraints and personal assistance services devices (PASD). On page 6, the policy directed staff to use the "Least Restraint Decision Tree" (appendix I) and the "Clinical Decision Making Guides" (appendix II) to decide on restraint use.

The Least Restraint Decision Tree identified for staff to initiate alternatives by referring to the Clinical Decision Making Guides, in addition to other interventions including applying a restraint. These directions were did not clearly indicate how these alternative were planned, developed and implemented. [s. 109. (f)]

5. The licensee has failed to ensure that the home's policy to minimize the restraining of residents addressed how the use of restraining would be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and Regulation.

Inspector #575 reviewed the home's policy titled Least Restraints, last reviewed March 30, 2015. On page 15, the policy indicated that a regular audit would be completed on a sample number of residents that had been assessed for a restraint or had a restraint applied. The audit would be based on the documentation prior to applying a restraint and after the restraint was applied. The home's policy did not address how the restraining would be evaluated to ensure minimizing of restraining and how they would ensure that any restraining that is necessary is done in accordance with the Act and Regulation. [s. 109. (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home's policy to minimize the restraining of residents includes: restraining under the common law duty when immediate action is necessary to prevent serious bodily harm to the person or others; the types of physical devices permitted to be used; how consent to use a physical device to restrain a resident is to be obtained and documented; alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and how the use of restraining is evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and Regulation., to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies, and that immediate action was taken if any discrepancies were discovered.

During an interview, the DOPCS confirmed that monthly audits were not being completed on the daily narcotic control count sheets. The inspector reviewed the home's policy titled, 'Drug Storage Area Inspections', policy no: XXI-20, revised August 2015, which identified that the DOPCS shall ensure that monthly inspections of all drug storage areas are completed. The policy further indicated that these inspections completed by the DOPCS shall confirm that records of narcotic controlled drug administration and inventory are up to date accurate. [s. 130. 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 ensuring that a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #11: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Throughout the inspection, Inspector #613 observed registered staff leave the Medication Administration Record Sheet (MARS) binder open on top of the medication cart located at the nursing station. The medication cart was positioned beside the hallway where visitors and other staff frequently walked by, displaying residents' medication records and exposing a residents' identification. The MARS binder was observed to be opened when no registered staff were present in the nurses station on various occasions.

During an interview, the DOPCS indicated that registered staff were expected to close the MARS binder to ensure confidentiality was maintained. [s. 3. (1) 11. iv.]

WN #12: 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 the home's Bladder and Bowel Management policy was complied with.

Inspector #575 and #613 reviewed the health care records of three residents. Resident #001, #004, and #008 were all identified as requiring the use of disposable briefs.

Three registered staff were interviewed regarding how residents' are measured for continence care products and how staff determine the most appropriate product. TL #102 indicated that there were no guidelines for measuring the proper fit of continence care products and that they were unsure who the supplier of the products was. RPN #105 indicated that they were not sure if residents were assessed for continence care products and RPN #112 indicated that there was no formal measurement taken to assess residents for continence care products and staff decide what product residents' should use.

During an interview, the DOPCS confirmed that there was no current or specific way for assessing residents for the most appropriate continence care product and that staff were using their own judgement as to what type of product should be used with each resident who is incontinent. The DOPCS was unaware that there was a way to assess residents for the use of proper product.

Inspector #575 reviewed the home's policy titled Bladder and Bowel Management - LTC, last reviewed June 8, 2015, which indicated that staff would assess residents who required continence care products for proper fit, using supplier guidelines. The policy further indicated that the resident should be measured for the most effective category of product according to their level of incontinence. [s. 8. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of resident's #004, #005 and #008's activity patterns and pursuits.

During interviews with residents #004, #005 and #008, they informed Inspector #613 that the home was lacking activities of their interests. The inspector completed a health care record review for all three residents. The most current care plan for resident #005 indicated that the resident had little involvement and lacked attendance at organized recreation. The inspector noted resident #004 and #008's care plans did not include their recreation preferences. No interdisciplinary assessments for residents #004, #005 and #008's activity patterns and pursuits were in their health care records.

During an interview, AC #103 indicated that the community the residents' reside in was small and that they knew most residents' past, their families and recreation interests. AC #103 stated that they completed assessments upon admission regarding resident #004, #005 and #008's activity patterns and pursuits by meeting with the resident and their family. AC #103 informed the inspector that this assessment was kept in the AC's office. The inspector requested copies of these assessments with respect to these residents' activity patterns and pursuits and the AC was unable to provide the requested information. [s. 26. (3) 16.]

WN #14: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents’ satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that annual residents' satisfaction evaluation of continence care products is completed in consultation with residents, substitute decision-makers (SDM) and direct care staff with the evaluations being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated.

During an interview, the DOPCS confirmed to Inspector #613 that residents' satisfaction evaluations of continence care products had not been completed with residents, SDMs, or direct care staff. Therefore, the licensee did not take into account the evaluation when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. [s. 51. (1) 5.]

2. The licensee has failed to ensure that there a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

According to the most recent MDS assessment, resident #001 was incontinent of bladder and usually continent of bowels. During an interview, RPN #101 indicated that the resident was dependent on staff, wore a medium brief during the day and a large brief during the night.

The inspector interviewed two staff regarding the supply of continence care products. TL #102 stated that they occasionally run out of medium briefs. TL #102 indicated that on two occasions in late summer and early fall, they ran out of the product for approximately one week. RPN #100 stated that they have run out of different products (not just medium) for a period of approximately a few days. RPN #100 stated they ran out of double extra large for a few days once and sometimes pull ups. [s. 51. (2) (f)]

WN #15: 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 has failed to ensure that they respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Inspector #575 reviewed the meeting minutes from the last two Residents' Council minutes conducted on June 29, 2015 and April 8, 2015. During both meetings, there were resident concerns raised and program ideas. The minutes indicated that the issues would be brought forward to AC #103 and the DOPCS.

During an interview with the Residents' Council Assistant (RCA) #110, they indicated that usually they would sent an email with any concerns brought forward in the Residents' Council meeting to the appropriate staff members. RCA #110 stated that typically concerns are resolved verbally and that in the past, responses are not received within 10 days.

The inspector interviewed AC #103 regarding responses to the Residents' Council concerns. AC #103 provided the inspector with email correspondence regarding the April 8, 2015 meeting. The inspector noted that the meeting minutes were provided to AC #103 and the DOPCS on April 10, 2015. It was not until May 14, 2015 (25 business days after receiving the concerns) that the concerns were addressed by both AC #103 and the DOPCS. [s. 57. (2)]

WN #16: 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).

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.

During an interview, the Continuous Quality Improvement Coordinator (QI) #104 stated that the satisfaction survey had not been brought to the Residents' Council for review prior to the survey being sent out to residents and families. QI #104 confirmed that they did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [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.

During an interview, QI #104 stated that the satisfaction survey had not been brought to the Family Council for review prior to the survey being sent out to residents and families. QI #104 confirmed that they did not seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

Issued on this 6th day of January, 2016

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

Original report signed by the inspector.

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) :	LINDSAY DYRDA (575), LISA MOORE (613)
Inspection No. / No de l'inspection :	2015_332575_0020
Log No. / Registre no:	029574-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 22, 2015
Licensee / Titulaire de permis :	LADY DUNN HEALTH CENTRE 17 Government Road, Box 179, Wawa, ON, P0S-1K0
LTC Home / Foyer de SLD :	LADY DUNN HEALTH CENTRE 17 Government Road, P.O. Box 179, Wawa, ON, P0S-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kadean Ogilvie-Pinter

To LADY DUNN HEALTH CENTRE, 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)

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 ensuring that all staff who provide direct care to residents receive annual training in all areas provided for in subsection 76 (7) of the Act.

This plan is to include but not be limited to the following:

1. Create a schedule that includes the following training needs:
   a). Abuse recognition and prevention
   b). Mental health issues, including caring for persons with dementia
   c). Behaviour management
   d). How to minimize the restraining of residents and where restraining is necessary, how to do so in accordance with this Act and the regulations. This shall also include training in the application, use and potential dangers of physical devices used to restrain residents and personal assistance services devices (PASD)
   e). Palliative care
   f). Falls prevention and management
   g). Skin and wound care
   h). Continence care and bowel management
   i). Pain management, including pain recognition of specific and non-specific signs of pain
   j). Techniques and approaches related to responsive behaviours

2.) Include how the licensee will maintain training records in order to ensure all staff have the required training, which may include an audit process.

3.) Include how the licensee will ensure that any other training needs identified in the Act and Regulations are provided to staff.

4.) Include how the licensee will ensure that the required training is provided to staff on an annual basis or any other time as specified in the Act and Regulations.

This plan may be submitted in writing to Long-Term Care Homes Inspector Lindsay Dyrda at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the inspector's attention at (705) 564-3133. This plan must be received by January 4, 2016 and fully implemented by March 18, 2016.

Grounds / Motifs :

1. The licensee failed to ensure that all staff who provide direct care to residents received 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).

On November 23, 2015, Inspector #613 requested the training records and resource training material from the Nurse Educator (NE) on abuse recognition and prevention and minimizing the restraining of residents. The NE informed the inspector that they had not provided the staff any education training in 2015 to date, that no education had occurred for approximately one year, that they had submitted an education plan but had not received approval, and that they were unable to provide education to staff until they received approval.

Inspector #613 asked the NE if training had been provided to staff in regards to the devices used by resident #001 and #008. The NE confirmed that no education had been provided to staff on the use of these devices and that the NE was not aware that these devices were being used. The NE also confirmed that there were no attendance lists or resource training material to demonstrate that education had been provided to staff on abuse recognition & prevention and restraints in the last 12 months.

Inspector #613 interviewed the Director of Patient Care Services (DOPCS) who confirmed that none of the mandatory education training had occurred yet in 2015.

The NE provided the inspector with training records for 2013, 2014 and 2015. In 2013, the records showed 27 out of 31 (87%) staff completed the Annual Review which consisted of reviewing the following policies:
-Residents Bill of Rights
-Home Mission Statement
-Staff Reporting and Whistle Blowing Protection
-Zero Tolerance for Abuse & Neglect
-Minimizing Restraints

In 2014, the training records showed that staff received the same topics for training as in 2013 with the addition of the Client Concerns Handling Program.
In 2015, the only training provided to staff was Gentle Persuasive Approaches

(GPA). This training was provided April 20, 27, May 4, and June 22, 2015. No other training records, resource material or attendance sheets were available.

The education the home provided to staff in 2013, 2014 and 2015 did not include all of the mandatory annual training as per the Long-Term Care Homes (LTCH) Act and Regulations. Under section 76(7) the following annual training is required:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations.

Under O.Reg 221 (1), for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which annual 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.

In addition, the licensee shall ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours and the training required under paragraph 4 of subsection 76 (7) of the Act includes training in the application, use and potential dangers of physical devices used to restrain residents and personal assistance services devices.

The NE provided the inspector their education plan for 2014 and 2015 which did not include all of the required mandatory annual training as per the LTCH Act and Regulations. The home had not provided all of the required education

training as per the LTCH Act and Regulations for the past three years.

The decision to issue this compliance order was based on the severity, which was determined to be minimal harm or potential for actual harm to the health, safety and well-being of all residents. Although there was no previous related non-compliance issued in this area, the scope was determined to be widespread, as this has the potential to affect all residents in the home. (613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 18, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall ensure that staff apply devices in accordance with any manufacturer's instructions.

Specifically, the licensee shall:

1). Train all staff who apply and monitor devices, on the application and use of resident #001's device;

2.) Ensure resident #001's device is the proper size according to the manufacturer's instructions;

3.) Conduct random audits and keep records of such audits to ensure staff are applying the devices properly;

4.) Develop a process to ensure that all staff are trained on all devices prior to application;

5.) Keep a copy of the manufacturer's instructions in resident #001's health care record.

Grounds / Motifs :

1. The licensee has failed to ensure that the physical device used to restrain resident #001 was applied in accordance with the manufacturer's instructions.

On November 17 and 18, 2015, Inspector #575 observed resident #001 with a device applied.

Inspector #575 reviewed the resident's plan of care and noted a physician's order for the device as needed (PRN). The inspector requested and was provided the manufacturer's instructions for the device and noted that the instructions stated the following:

-staff must have on going training and be able to demonstrate competency to use the device in accordance with instructions, facility policies and regulations;
-staff should test to make sure that the device is applied properly, as risk of serious injury may occur;
-always use the proper size device.

The inspector noted according to the resident's current weight, the resident would be required to use a certain size device, however, this was not the device currently being used.

The inspector interviewed two RPNs regarding the resident's device. RPN #100 stated that they had not received training on this particular device, that they were not sure how to properly apply it and that sometimes it did not fit properly. RPN #101 indicated that they did not receive training on how to properly apply the device and that they applied the device based on their own judgement.

The decision to issue this compliance order was based on the severity, which was determined to be actual risk of harm to the health, safety and well-being of this resident. The scope was isolated, however despite previous non-compliance (NC) issued under section 110, NC continues in this are in this area of the legislation. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 18, 2016

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_376594_0014, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan ensuring that every use of a physical device to restrain a resident under section 31 of the Act is documented without limiting the generality of this requirement, the licensee shall ensure that all assessment, reassessment and monitoring, including the resident's response.

This plan shall include a review of resident health care records for all resident's who require a restraint to ensure the requirements of O.Reg 110. (7) are satisfied.

This plan must include what training and re-training will be provided to staff, how and by what timeframe the home will have the training completed and maintain a record of this training.

This plan shall also include a process to ensure that staff are completing the restraint documentation adequately in order to satisfy all of the requirements as described in section 110. (7) pursuant to O.Reg 79/10. This process is to be completed on a regular basis.

This plan may be submitted in writing to Long-Term Care Homes Inspector Lindsay Dyrda at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the inspector's attention at (705) 564-3133. This plan must be received by January 4, 2016 and fully implemented by January 18, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that every use of a physical device used to restrain a resident was documented including all assessment, reassessment and monitoring, including the resident's response.

Inspector #575 reviewed the restraint records for resident #001, #002, and #008 for a period of approximately two months. The restraint record indicated that registered nursing initials were required every eight hours and coded either "N" for necessary or "NR" for no longer required. In addition, the restraint record included the following areas to document: when the restraint was applied, released, visually checked; when the resident was repositioned; the resident's response; the restraint type; the reason for the restraint; and staff initials for who applied the device and completed the monitoring.

The inspector noted the following:

For resident #001 on 40 occasions, the documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances; and on seven occasions, there were periods of time which failed to document any assessment, reassessment or monitoring of the restraint use.

For resident #002 on 41 occasions, the documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances; and on 10 occasions, there were periods of time which failed to document any assessment, reassessment or monitoring of the restraint use.

For resident #008 on 32 occasions, the documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances; and on 2 occasions, there were periods of time which failed to document any assessment, reassessment or monitoring of the restraint use.

During an interview, RPN #101 indicated that staff are to record on the restraint record when the restraint was applied, when the resident was repositioned, whether the resident tolerated the restraint, and what type of restraint was applied. RPN #101 confirmed that registered staff are to sign the restraint record every eight hours to indicate that the restraint was still required.

The inspector reviewed the restraint records with TL #102 who confirmed that the restraint records were not completed as required.

During an inspection completed November 2014, under inspection #2014_339579_0013, a previous compliance order (CO) was issued pursuant to O.Reg 79/10, s. 110. (7), the 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: the person who applied the device and the time of

application.

During a follow-up inspection completed June 2015, under inspection #2015_376594_0014, a CO was re-issued pursuant to O.Reg 79/10, s. 110. (7), the 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: the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response.

The decision to re-issue this CO was based on the severity, which was determined to be potential for actual harm to the health, safety and well-being of all three resident's. The scope was determined to be widespread, as 3/3 resident's who had restraints were affected. Despite previous non-compliance (NC) issued, NC continues in this are in this area of the legislation.
(575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 18, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 ensure that where bed rails are used, 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 the risk to the resident.

The licensee shall:

1.) Conduct bed system assessments for all residents who require the use of bed rails, following the Health Canada guidance document;

2.) Train staff on the use of bed rails and bed systems, and specifically, zones of entrapment;

3.) Maintain a record of the resident assessment and bed system assessment, including the type of mattresses and beds used for each resident;

4.) Ensure steps are taken to prevent resident entrapment where dimensional limits exceed the recommended limits.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident

was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Inspector #575 observed large gaps in the bed rails for three resident's, specifically in zone 1, 6, and 7.

The inspector interviewed the TL #102 regarding the assessments conducted to determine if a resident required the use of bed rails. TL #102 indicated that bed rail assessments were conducted on admission, depending on some of the information from CCAC, safety issues and concerns. Assessments were also conducted quarterly via the MDS assessment, interviews with staff, family and residents. TL #102 was not aware of the Health Canada guidance document regarding assessing the bed system. TL #102 mentioned that there was a case of one resident in the home who started to have bruises on their legs and it was determined that that the resident's legs were touching the bed rails and their legs were getting caught on occasion within the space of the bed rails. No assessments on any other resident's bed system had been conducted.

The inspector interviewed the DOPCS regarding bed rail assessments and entrapment. The DOPCS indicated that after the previous Resident Quality (RQI) Inspection in 2014, the home looked into bed entrapment testing and reached out to a third party regarding the required tools and testing, however, they were unable to obtain the required tools for entrapment testing. The DOPCS also indicated that the bed and mattress were bought together as a system, no assessments of the bed system had been conducted, and they were not aware of the Health Canada guidance document.

A memo from the Ministry of Health and Long-Term Care dated August 21, 2012 was sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document ‘Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards’ as a best practice document in their homes.

The guidance document indicated the dimensional limit for zone 1 should be 120 mm or 4.75 inches. The guidance document further indicated that to reduce the risk of head entrapment, openings in the bed system should not allow the widest part of a small head to be trapped. Therefore, a head breadth dimension of 120mm was used as the basis for its dimensional limit recommendations. The

population at greatest risk is defined as “patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement or who get out of bed and walk unsafely without assistance. These patients most often have been frail, elderly or confused”.

The inspector observed the resident beds that had large gaps and noted the bed type was Hill Rom. The inspector measured the dimensions for zone 1 for the Hill Rom beds and noted the median of the rail measured 139.7 millimeters (mm) or 5.5 inches and both ends of the bed rail measured 107.95 mm or 4.25 inches. Zone 6 and 7 were both measured at 139.7 mm or 5.5 inches.

The decision to issue this compliance order was based on the severity, scope and compliance history. The severity was determined to be potential for actual harm to the health, safety and well-being of residents and the scope was a pattern as it has the potential to affect those resident's who require the use of bed rails. A previous related non-compliance (NC) was issued during the Resident Quality Inspection conducted in 2014, however NC continues in this area of the legislation. (575)

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

Order # / Ordre no : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_376594_0015, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that resident #001's written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Specifically, the licensee shall ensure:

1. The physician's order provides clear instructions regarding the use of the device, including the purpose of the device and when it is to be applied.

2. A consent is signed that clearly indicates what device is to be used and why.

3. The care plan is updated and provides clear direction regarding when staff can apply the device, according to the physician's order.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001's plan of care set out clear directions to staff and others who provide direct care to the resident.

On multiple occasions, Inspector #575 observed resident #001 with multiple devices in use. The inspector interviewed two registered staff regarding one of the devices. RPN #100 stated that it was used during certain times for positioning and RPN #101 stated that the resident did not always require it and it was not always required at certain times.

The inspector reviewed the resident's health care record. The inspector observed a physician's order that indicated the devices to be used. A signed consent and the resident's care plan was observed that indicated the devices to be used, however, the consent and care plan varied from the physician's order.

The inspector determined that the plan of care did not provide clear directions to staff and others who provided direct care to the resident as the physician's order did not specify the purpose of the device, the consent included multiple devices however, part of the consent indicated the use of one device or another (staff were observed using both at the same time), and the care plan indicated different uses for the device. Staff were not consistent with the purpose and use of one of the devices and RPN #100 and #101 indicated that staff were not trained on the proper use of this device and they were not aware of the manufacturer's instructions.

During an inspection completed June 2015, under inspection #2015_376594_0015, a compliance order (CO) was issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) the licensee has failed to ensure shall ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

The decision to issue this CO was based on the severity, scope and compliance history. The severity was determined to be minimal harm or potential for actual harm to the resident's health, safety and well-being. The scope was isolated, however despite previous non-compliance, NC continues in this area of the legislation. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 08, 2016

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.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

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

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

Issued on this 22nd day of December, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Lindsay Dyrda

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