Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 08, 2016;	2016_286547_0019 (A1)	013509-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON N3H 5L8

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

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON K1K 0S6

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

LISA KLUKE (547) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

Order CO #001 has been amended to change the compliance date from September 9, 2016 to September 16, 2016 as per request from Director of Care.

Issued on this 8 day of September 2016 (A1)

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

Original report signed by the inspector.

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LISA KLUKE (547) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 19, 20, 21, 22, 25, 26, 27, 28, 29 and August 2, 2016

The following critical incidents log #'s: 020238 /019437 /020887-16 related to alleged visitor to resident abuse, 019175-16 related to alleged staff to resident abuse and a complaint log# 017233-16 related to housekeeping issues and pest control were conducted concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Extendicare Regional Director, acting Directors of Care (DOC), RAI Coordinator, Program Director, Maintenance Supervisor, Office Manager, Food Service Supervisor (FSS), Registered Dietitian (RD), Physiotherapist (PT), Physiotherapy Assistant (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activities Aide, a Cook, Housekeeping Aides, Student Volunteers, Residents and Family Members.

In addition the inspection team, reviewed resident health care records, food production documents including planned menus and resident daily food and fluid intake sheets, resident and family council minutes, Volunteer Handbook, Room Temperature Records. Documents related to the home's investigations into four critical incidents reported by the home were reviewed as well as policies and procedures related to Infection Control, Prevention of Abuse, Falls Prevention and Management Program, Assisting the Resident to Eat,

Preventative Maintenance Program and Complaints. The inspection team observed aspects of resident care and interactions with staff, along with medication administration and several meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Safe and Secure Home

Skin and Wound Care

Trust Accounts

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

7 WN(s)
5 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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 :

The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Inspector #655 observed resident #039's bed to have one three quarter length bedside rail in the up position on July 20, 22, 25, 29, and August 2, 2016.

On July 22, 2016, resident #039 told Inspector #655 that he/she believed the bed rail was dangerous as his/her right knee hurts when it gets stuck inside the bed rail and that he/she would like the bed rail to be removed. On August 2, 2016 resident #039 indicated to Inspector #655 that he/she has also climbed over this bed rail occasionally.

During an interview on August 2, 2016, resident #039's spouse indicated to Inspector #655 that the residents' bed rail was loose and that it had been this way for quite some time. Inspector #655 also observed the resident's bed rail to be loose on August 2, 2016.

Inspector #655 reviewed a document entitled "Cardinal Health- Facility Entrapment Inspection Sheet" that was not dated, which indicated that there was a loose bed rail on resident #039s' bed and that bed entrapment zones two and three related to bedside rails had failed during this assessment. Another document entitled "Bed Entrapment Audit Results" also not dated indicated that 62.5% (40 out of 64) of the

bed systems that were audited failed the facility’s bed entrapment inspection , which included resident #039's bed.

Inspector #655 reviewed another document entitled “Extendicare Bed rail Device Assessment Survey – Appendix III” dated a specified date in May 2016, indicated that resident #039’s bed system had two bed rails that were not needed and not secured. This document further indicated under “actions to be taken to reduce entrapment for this resident” that both bed rails were to be removed from resident #039’s bed. On the same document, it is indicated that the bed rails were to be removed from the beds of 15 other residents who reside on the same home area as resident #039.

RN #107 indicated to Inspector #655 during an interview on July 25, 2016 that both of resident #039's bed rails were suppose to be removed based on the results of the bed system assessments noted above. RN #107 also indicated on August 2, 2016 that (who was also acting as Director of Care on this day) that it is the Maintenance Supervisor's responsibility to remove resident #039’s bed rails.

The Maintenance Supervisor indicated to Inspector #655 during an interview on August 2, 2016, that it is his responsibility to fix and/or remove bed rails as required since his arrival in the home in May 2016, but that he was not made aware of resident #039s’ loose bed rail or that the bed rails were to be removed as identified on the “Extendicare Bed rail Device Assessment Survey – Appendix III”.

On August 2, 2016, neither RN #107 or the Maintenance Supervisor were able to speak to any actions that had been taken since the “Cardinal Health Facility Entrapment Inspection Sheet" and “Extendicare Bed rail Device Assessment Survey – Appendix III” dated a specified date in May 2016 had been completed.

On August 2, 2016, resident #039s’ loose bed rail remained in the up position.

The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment.

There was a previous related non-compliance as a result of RQI 2015_286547_0025 in December 2015 (r. 15. 1 (a)).

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 the plan of care is based on an assessment of resident #017's needs and preferences related to falls.

Resident #017 was admitted to the home on a specified date in 2013 and an assessment completed on a specified date one year after the admission identified the resident as high risk for falls related to cognitive and mobility impairments. Resident #017's most recent fall occurred on a specified date in the morning while trying to get out of bed to go to the bathroom. Resident #017's bed did not have

any bed rails on the bed at this time. Housekeeping aide #114 discovered resident #017 sitting on the floor next to the bed with the bed mattress flipped off the bed and stuck behind the resident.

Resident #017 had his/her own personal mattress and bed frame until a specified date when the home replaced them with the home's bed frame and mattress.

The resident's Substitute Decision Maker (SDM) indicated to Inspector #547 that on this date when resident #001's bed frame and mattress was changed, that he/she identified concerns to the RAI coordinator, Administrator and the Senior Manager regarding the resident's mattress not properly fitting the bed frame as the mattress moved too easily across the top of the bed frame from side to side, posing a safety issue for falls. The SDM asked to have one bed rail placed on the resident's bed for safety to keep the mattress in place however the RAI coordinator indicated to the SDM that a bed rail was not required for the resident and that the mattress would no longer move once the resident would lay in bed.

RN #107 indicated to Inspector #547 that bed assessments were conducted by the RAI coordinator, the previous DOC and the previous Maintenance Supervisor. RN #107 indicated these assessments should have been identified on the home's 'Facility Entrapment Inspection Sheet'.

Inspector #547 reviewed resident #017's health care records and could not locate any assessment of the resident's new bed system related to resident safety and falls prevention as identified by the SDM's concerns and preferences on the day the resident received the new bed system.

The Extendicare Regional Manager (ERM) indicated to Inspector #547 that all beds are required to have a safety assessment to ensure that the mattresses properly fit the bed frames in the home, as they should not be able to move across the top of the bed frames. The ERM indicated that homes are provided with different mattress keepers to ensure resident safety and that every bed system should have this assessment completed.

Resident #017 was changed to a new bed and mattress on a specified date in March 2016 and the SDM requested one side rail to be applied to the bed frame as the resident was a risk for falls. No assessment of the resident's need for bed rails related to fall risk was completed or any safety assessment of the resident's bed system related to the resident's risk of falls. [s. 6. (2)]

2. The licensee has failed to ensure that resident #016's transfers were reassessed and the plan of care reviewed and revised when the resident's care needs changed.

During this inspection, Inspector #655 did observe resident #016 had a small, light-yellow coloured bruise on a specified area.

Resident #016's health care record review indicated in the progress notes on a specified date prior to this inspection that RPN #123 stated that " PSW reported at the end of the evening shift, that resident #016 had a large bruise and this resident told RPN #123 it was caused by a specific piece of equipment used during transfers".

Resident #016 indicated to Inspector #655 that he/she was injured while a PSW was transferring resident #016 from bed to wheelchair with this same piece of equipment. Resident #016 further indicated that he/she had been injured on more than one occasion with other staff members as well while using this same equipment and that to his/her knowledge, there has not been any new changes or assessments of transfers since this concern was reported a few months prior to this inspection. Resident #016 indicated that he/she remained concerned that he/she may be hurt again by this specified piece of equipment during transfers that occur more than once a day to get in and out of bed.

PSW #122 indicated to Inspector #655 during an interview on July 28, 2016, that a specific coloured sticker on the pictogram above resident #016’s bed signified that a specific piece of equipment is to be used for transfers. PSW #122 indicated that some staff had difficulty using this specific piece of equipment with resident #016 due to the residents positioning.

PSW #103 indicated that this specified piece of equipment is not the proper item to use for resident #016. PSW #103 explained that staff brought this to the attention of the previous Director of Care(DOC), but they were informed that this item could not be changed. When asked if there had been any modifications made at all to this item since this specified date a few months prior to this inspection when it is documented that resident #016 reported being bruised by this specified piece of equipment), PSW #103 indicated that there had not been.

RN #107 indicated during an interview that while the physiotherapist assesses

residents for transfers, they do not assess for the appropriate piece of equipment. She indicated that there was no referral made to physiotherapy after resident #016 reported bruising related to this specific item on a specified date. RN #107 indicated that because the concern was related to this piece of equipment, it was referred to the Director of Care at the time; who was responsible for the initial assessment. In a second interview on the same day, RN #107 was not able to locate any documentation to demonstrate that any interventions or modifications had been made to this specified piece of equipment to prevent bruising.

The Acting Director of Care (ADOC) #124 indicated during an interview with Inspector #655 that this is a safety concern. She indicated that when a resident has reported being bruised by a specified piece of equipment during transfer, it is the expectation that a reassessment would be done to ensure the residents safety during transfers and that the appropriate piece of equipment is being used. ADOC #124 indicated that a physio referral would likely be initiated and that the resident should also be fitted for a proper transfer equipment. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure resident #017's LTCH bed frame and mattress needs and preferences are reassessed related to falls prevention and that resident #016's mechanical lift transfers are reassessed and the plan of care reviewed and revised based on resident #016's care needs to prevent further injury, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident ambulation equipment are kept clean in the home.

On a specified date during this inspection, Inspector #547 noted urine odours upon entering resident #016 and #045's bedroom. Both residents were in bed and both resident wheelchairs were at their bedsides. Resident #016's wheelchair was noted to have an area of disrepair that had turned brown. Dried food matter remained stuck to the right side of the seat that also was identified by Inspector #655 five days earlier.

Resident #045's wheelchair was noted to be soiled with dried white matter to the seat and leg rests. Resident #016 indicated that he/she has never noticed any staff cleaning his/her chair. It was noted that the back of the resident's wheelchair had odours. RN #107 indicated to Inspector #547 that the status of these wheelchairs was not acceptable and that she would verify when the residents wheelchairs were last cleaned.

Resident #032's wheelchair was observed to be soiled with dried food matter to the left side of the chair and wheel. Resident #032 also has a second wheelchair in his/her room that was also noted to have a heavy build up of dried food matter and debris to the right arm rest and electric control stick on two separate dates during this inspection.

Resident #009's wheelchair was observed by Inspector #126 on a specified date to be soiled with debris and had odours of urine.

PSW #103 indicated to Inspector #547 that the resident's ambulation equipment is suppose to be washed on night shift by the Personal Support Workers(PSWs) on the night before the resident bath/shower. PSW #103 indicated that if they notice a resident's chair as soiled that they can wipe it down, but if the chair padding is soiled, it can only be done on nights, so that it has time to dry.

RN #107 indicated to Inspector #547 that the previous DOC in the home had developed an ambulation equipment cleaning schedule however upon review of the home's records, she indicated that this cleaning schedule was never implemented. RN #107 indicated that PSW staff are also aware that if a resident's ambulation equipment is noted to be soiled, that they are required to wipe off any debris or food matter, before it becomes stuck on the equipment. RN #107 indicated that the resident ambulation cleaning schedule will be implemented. [s. 15. (2) (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 resident's ambulation equipment is cleaned in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that RN #126 who had reasonable grounds to suspect that abuse of resident #006 by anyone that resulted in harm immediately report the suspicion and the information upon which it is based to the Director.

Resident #006 returned to the home from an outing on a specified date and PSW #125 observed a "mark" in a specific area on resident #006. Resident #006 indicated to have been hit by a specified person. PSW #125 reported this incident to RN #126 on duty at the time as per the home's documented investigation report.

Resident #006's progress notes one hour later on this specified date, stated that " RN #126 tried to begin an investigation of this incident however resident #006 indicated that the issue was too personal". RN #126 further indicated that "follow-up will be required".

The Director of Care (DOC) became aware of the incident three days later and notified the Director and initiated her investigation. As such, RN #126 in charge at the time of becoming aware of resident #006's physical abuse by a specified person did not immediately report the incident of abuse to the Director as required. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all nursing staff are aware of when there is reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm, immediately report this suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that included a process to ensure that food service workers and other staff assisting residents were aware of the residents’ diets, special needs and preferences.

On a specified date during this inspection during the lunch service in one of the home's dining rooms, three volunteers were observed by Inspector #593 to be providing beverages to residents from the beverage cart. There was no diet roster observed on the cart or in the dining room that the volunteers were referring to when providing beverages to residents.

Six days later during the AM nourishment pass on one wing of the home, PSW #102 was observed by Inspector #593 to be providing beverages to residents in this area. There was no diet roster observed on the cart during the service.

PSW #102 reported to Inspector #593 that usually there was a book on the cart which listed each resident and their special requirements, however it was not there today. PSW #102 further reported that they know the residents well and so did not need to refer to the book for their dietary requirements.

Seven days after the initial meal observation, Inspector #593 noted during the breakfast service in one of the dining rooms that an activity aide #100 and a volunteer were observed to be providing residents beverages from the beverage cart. There was no diet roster observed on the cart or in the dining room that the staff member or volunteer were referring to when providing beverages to residents.

Activity Aide #100 reported to Inspector #593 that they have been in the home for eight years and so they know the residents well. They added that if there was a new resident, they would check their diet type. When asked about the volunteers providing beverages to residents, Activity Aide #100 responded that she trains the volunteers which included the residents diets, otherwise they were not supposed to hand out anything to residents. Activity Aide #100 further reported that there is a diet binder they can refer to if necessary. The diet binder was observed in the kitchen at this time.

On this particular day, during the AM nourishment pass on one identified wing, PSW #111 was observed to be providing beverages to residents in this area. There was no diet roster observed on the cart during the service.

PSW #111 reported to Inspector #593 that there used to be a diet list attached to the cart however unfortunately it was not there anymore and he does not know why it was removed. PSW #111 further reported that this was not his usual unit but he still knows the residents however would have to check with the regular staff for any changes or new residents.

RN #107 reported to Inspector #593 that the PSWs are required to refer to the diet book during meals and during the nourishment pass. The book is updated by dietary and should be placed on the cart when the cart is set up with snacks and beverages for residents. [s. 73. (1) 5.]

2. The licensee has failed to ensure that the home has a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

Volunteer #120 was observed by Inspector #593 during the lunch meal service in a specified dining room, to feed fluids to residents #013, #015, #042 and #043. Volunteer #120 was observed to be standing while feeding the seated residents.

Volunteer #120 reported to Inspector #593 that they had not received any training by the home related to feeding of residents.

Volunteer #120 was observed by Inspector #593 to feed soup to resident #042 during the lunch meal service in a specified dining room. Volunteer #120 was observed to be standing while feeding the seated resident.

Volunteer #121 was observed during the breakfast meal service in the same dining room to be feeding orange juice, cereal and pureed fruit to resident #016 and porridge to resident #001. Volunteer #121 was observed to be standing while feeding the seated resident.

A review of resident #001’s care plan found that the resident required extensive assistance for eating by one PSW.

A review of resident #013’s care plan found that the resident had a chewing difficulty and required a minced textured diet.

A review of resident #015’s care plan found that the resident required extensive assistance by one staff as they were unable to feed themselves.

A review of resident #016’s care plan found that the resident was unable to feed themselves with total dependence on PSWs to feed all food and fluids. It was also documented that the resident was a choking risk.

A review of resident #042’s care plan found that the resident required extensive assistance for eating and was a risk for choking.

A review of resident #043’s care plan found that the resident required extensive assistance and PSW’s were to assist the resident throughout the entire meal.

Activity Aide #100 reported to Inspector #593 that the volunteers shadow her as part of their training, this includes feeding residents. They are told to take cues from the PSWs however what they are told depends upon the resident that they are feeding and this can include feeding slowly, using a teaspoon and dipping hard foods into liquids to soften them. Activity Aide #100 further reported that there was no formal training for volunteers related to feeding of residents.

Program Manager #101 reported to Inspector #593 that the volunteers usually

provide assistance only to the activity tables in the dining room to seat residents who need minimal assistance. However as they had multiple volunteers in the home, they had them assist with other tables including those with residents requiring extensive feeding assistance.

A review of the home’s policy titled: “Assisting the Resident to Eat RESI-05-02-11” dated December 2012, found that staff are to sit down beside the resident when feeding. [s. 73. (1) 10.]

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 food service workers and other staff assisting residents are made aware of the residents' diets, special needs and preferences, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures that were developed by the home for addressing incidents of lingering offensive odours were implemented.

Inspector #547 noted an odour of urine in resident #037's bedroom on five specified dates during this inspection and resident #023's bedroom and bathroom on three specified dates.

Inspector #547 reviewed a specific wing's housekeeping schedule that is kept on the housekeeping carts to identify when resident's rooms are deep cleaned. This housekeeping schedule folder also contained Odour control monitoring tool samples #HKLD-05-03-08 appendix 1 for staff to complete as required.

The maintenance log book for this same wing was reviewed for the last five month period and no resident rooms were identified to have lingering odours or completed odour control monitoring tools to address incidents of lingering offensive odours from housekeeping or nursing staff in the home.

Housekeeper #115 indicated to Inspector #547 that they follow the written cleaning schedule and will identify what rooms were deep cleaned and other rooms that required special attention on their shift. The housekeeping aide indicated that the home has developed forms that are to be completed if they cannot manage odours in resident areas. Housekeeper #115 indicated that the home does have a product to use for offensive odours, that is directly applied to washcloths or mop heads before they do the cleaning. Resident #037's room had not been identified as a room that required special attention for odours. Upon review of the unit cleaning schedule, it was noted that resident #037's room had been deep cleaned the day prior to all the odour observations for this resident's room.

Housekeeper #115 further indicated that resident #023's room was identified as a room that required special attention for odours and indicated that they use this specified urine contaminant product to clean this resident's room daily. Resident #023's room had been deep cleaned on a specified date in the last month.

Inspector #547 interviewed the home's Maintenance Supervisor covering for housekeeping during the period of this inspection, indicated that lingering odours should not be present and that staff are to identify the resident area on the lingering odour sheets or the maintenance log books to communicate to management to begin a plan of action.

Inspector #547 returned to resident #023 and #037's bedrooms on a specified date after bringing this issue to the home's attention and odours no longer remained present after the implementation of the home's procedure to address incidents of

offensive odours. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures that were developed by the home for addressing incidents of lingering offensive odours were implemented by nursing and housekeeping staff, to be implemented voluntarily.

WN #7: 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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s menu cycle included alternative choices of entrees and vegetables for resident #018 at lunch and dinner.

Resident #018 reported to Inspector #547 that he/she did not receive choices at

mealtimes and the home had often provide him/her with food that he/she could not eat.

Resident #018 reported to Inspector #593 that they were not given choices at mealtimes as most of the food on the menu had specified items that upset the resident's stomach.

A review of resident #018's current care plan found a focus documented as: Gastro-intestinal condition with a specified digestive medical diagnosis. Interventions were documented to manage this including: Food Service Supervisor and POA have reviewed current menu cycle and identified best meal choices for the resident and provide a regular diet with specified interventions. Resident #018 reports that he/she cannot tolerate certain specified spices as they upset his/her stomach. When resident refuses both menu options out of fear of indigestion, to offer the resident specified items.

A review of resident #018's most recent dietary quarterly summary found documented that the resident was able to consciously choose his/her meal options all while avoiding potential allergens. Resident #018 was at high nutritional risk due to food allergies and significant weight loss.

Resident #018 was observed by Inspector #593 to be offered both meal options during the lunch meal service. The resident was observed to ask "which one can I have?" The staff member checked with the kitchen and returned with one of the meals for the resident. The meal provided to the resident was the meal that was checked on the residents' individualized menu as appropriate for the resident.

During an interview with Inspector #593, cook #118 reported that there was a specialized menu posted in the kitchen for resident #018 due to dietary restrictions. Cook #118 further reported that resident #018 was only given one choice at mealtimes.

Registered Dietitian #117 reported to Inspector #593 that the dietary manager and resident #018's family chose the options on the menu that were suitable for resident #018 and the process at meals was that both options were presented to the resident, the resident would then ask the staff which meal he/she could have and they would bring the resident the meal choice from his/her individualized menu.

A review of the residents’ individualized menu for Spring/Summer 2016 found, out of 42 documented lunches and dinners, there were 35 entrees marked as suitable for resident #018. For the other seven meals, sandwiches or eggs were marked as the alternative. There was only one meal period in the 21 day menu cycle where both entrée choices were marked as suitable for resident #018. [s. 71. (1) (c)]

2. The licensee has failed to ensure that the home’s menu cycle was reviewed by the Residents’ Council.

The President of the Residents’ Council reported to Inspector #593 that the Dietary Manager does regularly attend Resident Council meetings to ask the residents for feedback on the current menu posted however they do not bring the menu for the residents to review.

Activity Aide #100 and assistant to the Residents’ Council reported to Inspector #593 that the Dietary Manager does attend council meetings to ask the residents for feedback on the current menu posted however they do not bring the menu for the residents to review before it is implemented.

Program Manager #101 confirmed with Inspector #593 that the menu is not reviewed with the council before implementation.

A review of the January to June, 2016 Resident Council minutes found documentation related to the Spring/Summer menu for 2016. In these minutes it was documented “Dietary Manager was present to discuss the meal and snack times, as well as the new Spring/ Summer menu”. However as reported by the Residents Council and confirmed by Activity staff, the residents were not provided with the menu for review. [s. 71. (1) (f)]

Issued on this 8 day of September 2016 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LISA KLUKE (547) - (A1)

Inspection No. / No de l'inspection : 2016_286547_0019 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 013509-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Sep 08, 2016;(A1)

Licensee / Titulaire de permis : CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301, c/o Southbridge Care Homes Inc., CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : MANOIR MAROCHEL
949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Bipin Raut

To CVH (No.4) GP Inc. as general partner of CVH (No.4) LP, 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. 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 :

(A1)
The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and that other safety issues related to the use of bed rails are addressed.

The plan will include the following:

1. A process for reassessment of the resident and resident bed systems to ensure that the assessment information is up to date, and to formally capture information such as (but not limited to): the assessment of the residents' need for the bedrails, the method of evaluation for entrapment zones #1-7, the date of the evaluation; and corrective actions to be taken as a result of these evaluations.

2. A process for ensuring that the outcome of bed system assessments including facility entrapment inspections and bedrail device assessments will be communicated to staff, specifically the individual(s) responsible for correcting the matter of concern.

3. A process for ensuring the appropriate corrective action is taken, and that the date upon which the corrective action is completed is documented.

While this plan is being prepared and implemented, the licensee must ensure that all bed rails in use in the home, such as those on the identified bed system for resident #039 during the Resident Quality Inspection (RQI) 2016 are only used with appropriate entrapment prevention measures in place.

This plan must be submitted in writing to Michelle Jones, Long Term Care Home (LTCH) Inspector by fax (613) 569-9670 on or before August 25, 2016. This plan must be fully implemented by September 16, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Inspector #655 observed resident #039's bed to have one three quarter length bedside rail in the up position on July 20, 22, 25, 29, and August 2, 2016.

On July 22, 2016, resident #039 told Inspector #655 that he/she believed the bed rail was dangerous as his/her right knee hurts when it gets stuck inside the bed rail and that he/she would like the bed rail to be removed. On August 2, 2016 resident #039 indicated to Inspector #655 that he/she has also climbed over this bed rail occasionally.

During an interview on August 2, 2016, resident #039's spouse indicated to Inspector #655 that the residents' bed rail was loose and that it had been this way for quite some time. Inspector #655 also observed the resident's bed rail to be loose on August 2, 2016.

Inspector #655 reviewed a document entitled "Cardinal Health- Facility Entrapment Inspection Sheet" that was not dated, which indicated that there was a loose bed rail on resident #039s' bed and that bed entrapment zones two and three related to bedside rails had failed during this assessment. Another document entitled "Bed Entrapment Audit Results" also not dated indicated that 62.5% (40 out of 64) of the bed systems that were audited failed the facility's bed entrapment inspection , which included resident #039's bed.

Inspector #655 reviewed another document entitled "Extendicare Bedrail Device Assessment Survey – Appendix III" dated a specified date in May 2016, indicated that resident #039's bed system had two bed rails that were not needed and not secured. This document further indicated under "actions to be taken to reduce entrapment for this resident" that both bed rails were to be removed from resident #039's bed. On the same document, it is indicated that the bed rails were to be removed from the beds of 15 other residents who reside on the same home area as resident #039.

RN #107 indicated to Inspector #655 during an interview on July 25, 2016 that both of resident #039's bed rails were suppose to be removed based on the results of the bed system assessments noted above. RN #107 also indicated on August 2, 2016 that (who was also acting as Director of Care on this day) that it is the Maintenance Supervisor's responsibility to remove resident #039's bed rails.

The Maintenance Supervisor indicated to Inspector #655 during an interview on

August 2, 2016, that it is his responsibility to fix and/or remove bed rails as required since his arrival in the home in May 2016, but that he was not made aware of resident #039s' loose bed rail or that the bed rails were to be removed as identified on the "Extendicare Bedrail Device Assessment Survey – Appendix III".

On August 2, 2016, neither RN #107 or the Maintenance Supervisor were able to speak to any actions that had been taken since the "Cardinal Health Facility Entrapment Inspection Sheet" and "Extendicare Bedrail Device Assessment Survey – Appendix III" dated a specified date in May 2016 had been completed.

On August 2, 2016, resident #039s' loose bed rail remained in the up position.

The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment.

There was a previous related non-compliance as a result of RQI 2015_286547_0025 in December 2015 (r. 15. 1 (a)).
(655)

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

Sep 16, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

The written request for review must be served personally, by registered mail 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

Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8	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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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
Toronto ON M5S 2B1
Télécopieur : 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 8 day of September 2016 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LISA KLUKE - (A1)

Service Area Office / Bureau régional de services : Ottawa