Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 6, 25, 2015	2015_347197_0019	O-001981-15	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

MAPLEWOOD
12 MAPLEWOOD AVENUE BOX 249 BRIGHTON ON K0K 1H0

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

JESSICA PATTISON (197), AMBER MOASE (541), BARBARA ROBINSON (572), SUSAN DONNAN (531)

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): May 4-8, 11-15, 19, 20, 2015

Four additional Critical Incident Inspections were completed concurrently with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nutritional Care Manager, the Registered Dietitian, the RAI/Clinical Care Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Food Service Workers, a Physician, the Office Manager, a Restorative Aide, a Physiotherapy Assistant, maintenance staff, laundry staff, residents and resident family members.

The inspectors also completed a full tour of the home, reviewed resident health care records and relevant policies, observed medication pass, dining service and resident care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **15 WN(s)**
- **8 VPC(s)**
- **2 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. 110. (1)	CO #901	2015_347197_0019	197

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. 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).
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).
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).

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).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg. 79/10, s. 110 (1) in that a physical restraint was altered and not applied according to manufacturer's instructions.

On May 6, 2015 at approximately 1400 hours, Inspector #541 observed Resident #31 in the hallway on the way to an activity. The Resident's restraint was observed to be improperly applied at this time. The Resident was in the presence of staff until the activity was finished at approximately 1520 hours. Inspector #541 observed Resident #31 at 1520 hours and the Resident's restraint remained improperly applied and the Resident had started to take on an unsafe position. Inspector #572 also observed and confirmed the observations. Resident #31 indicated to Inspector #541 that she could not undo the restraint and that she will at times move around.

Inspectors #541 and #572 asked a restorative aide if Resident #31's restraint was appropriately applied and the staff member indicated being unaware of how to appropriately assess the application of the restraint and that it is determined by a technician. Inspectors then asked a Physiotherapy Assistant if Resident #31's restraint was appropriately applied and this staff member also indicated being unaware of how to appropriately assess the application of the restraint.

The Registered Practical Nurse (RPN), staff member #S100, was asked to observe Resident #31's restraint. The RPN stated that it appeared to not be applied properly, but was unsure of how to appropriately assess the application of the restraint. The RPN then assisted Resident #31 to adjust position at this time, as the resident had started to move.

Inspector #541 approached the Administrator, who then observed Resident #31's physical restraint and confirmed that it was improperly applied and noted there were zip ties applied which were not in accordance with manufacturer's instructions.

When asked how Resident safety is ensured when restraints are applied, the Administrator stated that hourly checks are performed to ensure appropriate application. The Administrator stated that the expectation is for all staff who monitor restraints is to be capable of determining safe application, in accordance with manufacturer's instructions. (541)[s. 110. (1)]

2. On May 6, 2015, Resident #41 was en route to an activity in dining room. Inspector #541 noted that the Resident had a restraint that was improperly applied. Inspector #572 also observed Resident #41 at this time.

The Administrator was immediately notified and she confirmed that part of the restraint was was secure and positioned appropriately but acknowledged that another was improperly applied and became more so with movement of the Resident. The Director of Care confirmed that the secure restraint would be in place whenever the other was utilized to ensure the safety of Resident #41 until it could be replaced.

On May 7, 2015, Resident #41's improperly applied restraint was replaced. Further observations of Resident #41 on May 6,7,12, 13 and 15, 2015, confirmed that the new restraint was safely applied, did not change with movement from the Resident and that it was consistently applied according to the manufacturer's instructions. [s. 110. (1) 1.]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all physical restraints are applied correctly, according to manufacturer's instructions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 221(1)5 in that training related to the application of restraints has not been provided for staff who apply physical devices or who monitor residents restrained by a physical device.

On May 6, 2015, Inspector #541 observed Resident #31 in the hallway on the way to an activity at approximately 1400 hours. The Resident's restraint appeared improperly applied, however, the resident was with a staff member. When the activity was completed at approximately 1520 hours, Inspector #541 observed Resident #31 again and the was still improperly applied. Inspector #572 was also present and confirmed the observations. Resident #31 was asked if able to undo the restraint, to which the Resident replied "no". Inspector #541 asked Resident #31 if he/she ever changes position and the Resident replied "yes".

Inspectors #541 and #572 asked a restorative aide, a physiotherapy assistant and the RPN #S100 if they were aware of how Resident #31's restraint is to be applied and all

were unaware of how to appropriately assess the application of the resident's restraint.

Inspector #541 approached the Administrator who then observed Resident #31's restraint and confirmed that it was in fact improperly applied and noted there were zip ties which were not in accordance with manufacturers' instructions.

On May 6, 2015, Inspectors #541 and #572 observed Resident #41 with a restraint applied improperly. The Administrator was immediately notified and confirmed that one part of the restraint was secure and positioned appropriately, but acknowledged that another was improperly applied and became more so when the resident moved. The Director of Care confirmed that the secure and properly applied restraint would be in place whenever the other was utilized to ensure the safety of Resident #41 until a new restraint could be applied. The restraint was replaced for Resident #41 on May 7, 2015.

When asked how resident safety is ensured when restraints are applied, the Administrator stated that hourly checks are performed to ensure safety. The Administrator stated the expectation is that all staff who monitor restraints to be capable of determining safe application.

On May 11, 2015, PSW #S109 was asked by Inspector #541 how to determine if a particular restraint is properly applied. The PSW stated that personally, if able to put three fingers between the resident and the restraint, it will not be too tight. When asked why this method, the PSW stated that this was standard knowledge. When asked if the home provides education related to the seat belt, the PSW replied yes.

On May 12, 2015, Inspector #541 asked PSW #S108 how a particular restraint is to be applied. The PSW indicated ensuring the Resident's back is against the chair and fits two fingers between the restraint and the Resident. When asked if the home provides education on the safe application of seat belts, the PSW replied that there is online education, as well as in-services provided by the home.

PSW #S106 was asked how a particular restraint is appropriately applied. The PSW indicated that one hand can fit in between the resident and the restraint. PSW #S106 was asked how the home provides education on the safe application of restraints and stated the home provides education at the start of shift, as well as in-services.

On May 12, 2015, Inspector #541 asked the Administrator for a copy of the education provided to staff regarding the safe application of physical devices/restraints. The

Inspector was provided with policy #CS-5.6 Restraint Monitoring as well as a sheet signed by staff between May 6-7, 2015 to indicate they had reviewed this policy. On May 14, 2015, Inspector reviewed policy #CS-5.6 and it did not contain information on the safe application of physical devices. The Inspector reviewed the policy with the Administrator who confirmed that this was the education provided to staff related to seat belt application. (541) [s. 221. (1) 5.]

Additional Required Actions:

CO # - 001 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. 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 comply with O. Reg. 79/10, s. 8(1)(b) in that they did not follow their policy in relation to resident falls.

O. Reg. 79/10, s. 48(1) states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury

The home's policy # CS-12.1 titled "Resident Falls" states the following on page 2 of 3:

PROCEDURE:
13. The post-fall assessment shall be initiated as soon as possible after the resident has been assessed and is safe and comfortable.

14. The post-fall assessment shall be completed within 24 hours of the fall and provided to the Director of Care for review. The completed post-fall assessment shall be filed in the resident's clinical record.

Resident #3 had falls on two specified dates. No record of the post-fall assessments were found in the Resident's clinical record and when asked, the DOC stated that she could not locate them.

Resident #23 had falls on two specified dates. No record of the post-fall assessments were found in the Resident's clinical record and when asked, the DOC stated that one assessment could not be found and that other was not completed due to the fact that a nurse from an agency was working on the shift when the fall occurred and would not have known the Resident Falls policy. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that post-fall assessments are completed according to the Resident Falls policy CS-12.1, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 15(2)(a) in that the home did not ensure that resident equipment, such as walkers and wheelchairs, are kept clean and sanitary.

During the course of the Resident Quality Inspection, May 4-8, 11-15, 2015, the following was observed:

Resident #10 - brown thick build-up on the seat of the wheelchair frame

Resident #34 - gray stain on seat of the wheelchair

Resident #16 - sandy, granular build-up on the seat of walker with thick white stains on the outside edge

Resident #5 - sandy, granular build-up along creases/edges of the seat

Resident #42 - build-up of white matter on the top right corner of the seat of the walker, along with nectar-like stains on the seat

Resident #18 - outside edge of walker has visible thick white spill marks

Resident #23 - brown matter along the edge of the wheelchair seat frame and brown spill stains on both hand brakes

On May 13, 2015, PSW #S112 and #S113 confirm that residents' personal equipment is scheduled to be cleaned twice a week according to the bath schedule and then staff sign the nightly duty record to confirm cleaning has been completed.

Review of the April 11, 2015 Family Council information meeting minutes, section three "compliments, concerns, comments":
Wheelchair cleaning; the area for improvement for Maplewood is ensuring that all wheelchairs are cleaned as needed.
Review of the nightly duties record from May 1-11, 2015: completed on May 1, 2 and 11, 2015

During an interview with the Administrator and the Director of Care, they confirmed that wheelchairs are scheduled for cleaning twice a week according to the resident bath schedule and signed when the duty is completed. [s. 15. (2) (a)]

2. The licensee has failed to comply with the LTCHA, 2007 s. 15(2)(c) in that the home furnishings and equipment are not maintained in a good state of repair.

The following observations were made during the Resident Quality Inspection May 4-8, 11-15, 2015:

Dining room doors: the left side dining room entrance doors have kick plates located on the lower portion of the inside of the doors.
-the kick plates are cracked/split and detaching along the outside edge of both doors
-both bottom corners the wood is frayed/chipped and also detached from the main frame
-the dining room floor where the wood grain tile and vinyl tile flooring join, the seams have a build up of dirt/food matter
-the wood grain tile flooring is heavily scuffed
-the footplates on the bottom of both sets of dining room doors are worn leaving heavy black scarring marks on the floor as well as compression trail like marks beginning to tear the flooring

Tub room:
-plastic trim on both sides of the entrance door are broken and jagged approximately 12 inches in length and 2 inches wide, pieces have been broken and detached from the wall
-left side end pillar in front of the whirpool tub lower floor wall section has a piece of ceramic tile broken out and away from the wall with sharp jagged edges

-right lower wall corner of the shower area has a piece of ceramic tile that is broken and missing with jagged edges
-cork board material like supply cupboard is worn, chipped and missing paint along the top and sides

Other areas:
-trim in the hallway along the wall near the entrance doors leading to rooms 2, 4, 5, 7, 8 and tub room are broken and pieces missing
-water damaged ceiling tile in the hallway above the Maple Lounge

Resident Rooms -
Rm 1: marks on walls, doors and door frames with chipped paint
Rm 2: marks on doors and door frames, also chipped paint, baseboard scuffed with brown stains, dark marks at base of toilet
Rm 3: marks on walls, doors and door frames, paint chipped, rust coloured stains at base of toilet and the seal is cracked and dried
Rm 5: crack in wall below window, scuffs on wall and chips out of paint in bathroom and around door frames
Rm 7: bathroom - rust surrounding the base of the toilet, caulking rusted, chipped, outlet drain pipe below the sink is scarred and areas of rust observed, bedroom - walls/doors/door frames have scuffs and chips out of paint
Rm 8: many scuffs/chips out of paint on walls and doors/door frames
Rm 9: scrapes/scuffs and chips out of paint on walls/doors/door frames in resident's bed/bathroom
Rm 11: tile floor marked with some chips, marks on walls, doors and door frames, paint chipped on baseboard heater
Rm 14: bathroom - large chunk out of wall in bathroom, many paint chips on inside of bathroom door, chips of paint missing
underneath window
Rm 13/15: bathroom door has chipped paint
Rm 16: bathroom - toilet seal has a black and rust matter around entire base, black marks along wall, black marks along base of wall in front of bed
Rm 17: bathroom - walls have many black marks, lightswitch cover has scotch tape over it and is dirty with black marks, baseboard heater in bathroom has no cover
Rm 18: bathroom has many black marks along wall
Rm 20: marks on doors, door frames and baseboard, also chipped paint on doors and door frames

Not maintaining the home's furnishings and equipment in a safe condition and a good state of repair presents potential risks to the health, comfort, safety and well-being of residents.

On May 15, 2015, the maintenance employee was interviewed and indicated being new to the position and has reviewed the corporate audits for the home and agrees that there are multiple areas of disrepair. The plan is to repair and paint to bring the home into a better state of repair and implement preventative measures over the next year.

The Administrator was interviewed on May 15, 2015 and confirms that there are areas of disrepair and that maintenance staff is working on prioritizing the repairs. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents' wheelchairs and walkers are kept clean and sanitary and that the home's furnishings and equipment are maintained in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 20(1) in that the home did not comply with their written policy that promotes zero tolerance of abuse and neglect of residents.

The following finding is in relation to log O-001076-14.

The home's policy # AM-6.7 titled "Reporting Incidents of Abuse" states on page 2 of 3:
PROCEDURE
1. Upon becoming aware of any of the following alleged, suspected or witnessed incidents, the home shall contact the Ministry of Health immediately:
- Abuse of a resident by anyone or neglect of a resident that resulted in harm or risk of harm to the resident;

On a specified date, Resident #7 was witnessed by a staff member to inappropriately touch two residents in the dining room.

The home's first contact with the Ministry of Health and Long-Term Care was via submission of a Critical Incident Report for resident to resident abuse twenty-four hours after the incident occurred. [s. 20. (1)]

2. The following finding is in relation to log #O-001892-15.

On a specified date, PSW #S126 and #S127 reported to RN #S125 that a family member of Resident #28 had expressed concerns about the rough care provided by PSW #S129 for Resident #28 and Resident #29 as they were being assisted to go to bed. The family member asked PSW #S126 and PSW#127 to complete the care for the Resident as otherwise the family member did not feel comfortable leaving the Resident to go home and the staff did as requested. The SDM for Resident #28 subsequently called RPN #S123 to report the allegations of rough care being provided by PSW #S129 for Resident #28 and #29 and this information was again provided to RN #S125.

In an interview on May 19, 2015, RN #S125 said that since she had been in the room with Resident #28 and #29 during the time that care was provided by PSW #S129 and did not personally receive any information from the family member, the incidents were not reported but instead, RN #S125 asked RPN #S123 to document the incidents.

In an interview on May 20, 2015, RPN #S123 confirmed writing a description of the concerns about care as requested by RN #S125 and placed it under the Administrator's door. She was under the impression that critical incidents such as this required reporting within 24 hours and wanted the Administrator to be able to take appropriate action.

In an interview on May 20, 2015 the DOC and the Administrator confirmed that RN #S125 should have reported the concerns about care immediately as per the home's

policy. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff follow the Reporting Incidents of Abuse policy # AM-6.7, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 50. (2)(b)(iv) whereby the licensee did not ensure that a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds was assessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of the health care record for Resident #27 indicates that the Resident has multiple health care conditions which have resulted in a Stage 2 ulcer.

Although treatments are documented as being completed on the Medication Administration Record, weekly wound assessments were not completed for a period of 23 days. In addition, there was no weekly wound assessment documented for a period of 13 days.

In an interview on May 11, 2015, RN #S103 acknowledged that the RPN who provides the wound treatment is expected to document a weekly wound assessment. The DOC confirmed that weekly skin assessments were not completed for Resident #27 as required. [s. 50. (2) (b) (iv)]

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 if clinically indicated, residents exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, are assessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #7: 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 73(1)8 in that a meal was not served course by course unless otherwise indicated by the resident or the resident's assessed need.

During a dining observation completed during the lunch meal on May 4, 2015, Inspector #541 observed Residents #20, #30, #27, #31 to be served their entree before they had finished their soup.
During the same dining observation, Residents #26, #22 and #2 were served their desserts before they had finished their entree.

On May 12, 2015, a lunch dining observation was completed and Resident #43 was observed to be served her entree before she had finished her soup. (541) [s. 73. (1) 8.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 73(2)(b) in that resident's who require assistance with eating or drinking were served their meal when no one was available to provide assistance.

Resident #24 is assessed at high nutritional risk and is provided with a nutritional supplement for weight maintenance. The Resident's current care plan states that the Resident is dependent on staff at meals, one staff is to remain with the resident from start to finish of meals and that the Resident requires extensive assistance. The care plan also states that the resident likes juice and to increase fluid intake during warm weather months.

On May 4, 2015, Resident #24 was observed during the lunch meal. Staff member #S130 was observed to provide assistance to the resident with soup and some of the hot entree. At approximately 1232 hours, S130 left the table to provide care to another resident. At this time, the Resident had about 60% of the hot entree and 2.5 glasses of fluid remaining. From 1232 to 1251 hours, Resident #24 sat with no assistance. At 1251 hours, staff member #S131 sat down to provide assistance to Resident #24, but did not re-heat the resident's hot entree. At 1309 hours, Resident #24 was observed with half a glass of juice but no staff providing assistance. The resident was taken away from the table at 1351 hours, without the rest of the juice being offered.

During dining observation on May 4, 2015, Resident #8 was observed sitting at the table with drinks at 1208 hrs, no assistance was provided. Resident #8 is identified in the current care plan as requiring total assistance to eat.

Resident #28 is identified as high nutritional risk due to a significant weight change. During dining observation on May 12, 2015, Resident #28 was observed to be sitting at the table with two glasses of fluids at 1200 hrs, no assistance was provided. At 1208 hrs a staff member set a cup of coffee in front of Resident #28 and stated "here's your coffee". Resident's eyes were closed and no assistance was provided until 1219 hrs. Resident #28 was provided with an entrée at 1228 hours and assistance was provided at that time, however, between 1232 hrs and 1245 hrs PSW staff member was observed to leave the Resident's table twice while fluids and entrée were still in front of the Resident. It is noted that a PSW staff member offered Resident #28 a nutritional supplement drink at the end of the meal service.(541) [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident meals are served course by course and that residents who require assistance with eating or drinking are served a meal only when someone is available to provide assistance, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 129(1)(a)(ii) whereby the licensee did not ensure that drugs are stored in an area or a medication cart that is secure and locked.

On May 4 and May 6, 2015, inspector #541 observed the care cart for PSW's positioned in a main hallway of the home with linen and numerous containers of prescription creams for residents visible and accessible. On May 12, inspector #572 observed the same care cart used by PSWs, again situated in a main hallway of the home. The cart had a loose net cover that allowed easy access to the contents of the cart which included linen and prescription creams for various residents. PSW #S107 noted that the prescription creams remain on the cart during the day shift and they are locked in the medication room in the evening.

In an interview on May 12, 2015, the DOC noted that all prescription medications should be locked when not being utilized and that the current process will be revised to ensure that drugs are stored in an area that is secure and locked. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that prescription creams are stored in an area or medication cart that is secure and locked when not in use, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 229(4) in that they did not ensure that staff participate in the implementation of the infection prevention and control program through improper storage and labelling practices in resident bathrooms.

Throughout the Resident Quality Inspection period, May 4-8, 11-15, 2015, the following was observed in resident's shared bathrooms:

Room 3 - unlabelled tube of barriere cream, unlabelled urine hat and slipper pan (572)
Room 4 - unlabelled urine hat stored on back of toilet, unlabeled urinal hanging on bar beside the sink (197)
Room 5 - unlabelled urine hat, barrier cream and toothbrush, all stored on back of toilet tank (197)
Room 7 - unlabelled bed pan and urinal stored on back of toilet, unlabelled barrier cream (197), dirty and unlabelled bed pan stored on back of toilet (531)
Room 8 - unlabelled urine hat, shave cream, moisturizer and urine sample cup stored on back of toilet tank (197)
Room 9 - unlabelled comb on paper towel dispenser, 2 incontinent products stored on the back of the toilet (197)
Room 11 - unlabelled urine hat (572)
Room 12 - unlabelled slipper pan, comb and brush with hair visible (572)
Room 13 and 15 - 3 unlabelled urinals, two stored on the back of the toilet (541)
Room 14 - three urinals, two are unlabelled, one urinal is stored inside another, unlabelled barrier creams, all stored on on back of toilet (541)
Room 16 - two unlabelled urinals, one stored on the back of the toilet (541)
Room 17 - three unlabelled urinals, two stored on the back of the toilet (541)
Room 18 - unlabelled urine basin stored on the back of toilet (541)

During an interview with the Infection Prevention and Control Lead, staff member #S105, she indicated that she was not aware that bed pans, urinals, personal items, etc., were unlabelled and being stored on the backs of toilet tanks. She did state that the home does have racks that have not yet been installed that bed pans and urinals will be stored on in the future. She also acknowledged the risk for spread of infection when bed pans/urinals are left dirty and unlabelled in shared bathrooms and stated that going forward they could label these items. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program by properly cleaning, labelling and storing residents' bedpans, urine collection containers and personal items in shared bathrooms, to be implemented voluntarily.

WN #10: 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. (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 comply with LTCHA, 2007 s. 6 (10)(b) whereby the licensee did not ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

A review of the health care record for Resident #6 indicates that the Resident has multiple health conditions including an inability to complete oral care independently.

The current care plan for Resident #6 indicates that the Resident is to have eye glasses available at all times for certain activities. It also states that the resident wears dentures and needs reminders to soak them overnight.

In an interview on May 15, 2015, the Resident indicated not having dentures and does not need to use eye glasses.

In an interview on May 15, 2015, RN #S103 and PSW #S107 stated that the Resident doesn't want to use dentures; the Resident eats a texture modified diet independently with cueing. In addition, Resident #6 does not wear glasses at all. RN #S103 stated that she updates the Resident's care plan and was not aware of the change in requirement for eye glasses and dentures.

In an interview on May 15, 2015, the Director of Care confirmed that Resident #6 should have had a care plan update to reflect the current status of the Resident. [s. 6. (10) (b)]

2. The following finding is in relation to log O-000477-14.

A review of the health care record and Critical Incident #2717-000010-14 for Resident #29 indicates that the Resident has multiple diagnoses including dementia.

The current care plan for Resident #29 indicates that Resident #29 utilizes a specified piece of equipment for mobility. The care plan also states that the Resident requires a specified level of monitoring.

In an interview on May 20, 2014, RN #S103 and RPN #S104 noted that Resident #29 does not require or receive the specified monitoring and that due to the Resident's physical decline, Resident #29 no longer utilizes the specified piece of equipment for mobility.

In an interview on May 20, 2015, the Director of Care confirmed that Resident #29 should have had an update to the Care Plan to reflect the current status of the Resident. [s. 6. (10) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 31(3)(e) whereby the licensee failed to ensure that the written staffing plan is evaluated and updated at least annually in accordance with evidence-based practices.

On May 14, 2015, the Administrator acknowledged that there was no annual evaluation of the staffing plan for 2014, as the home was adjusting their previously inconsistent staffing patterns and will resume annual evaluation next year. [s. 31. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 34(1)(a) in that a resident did not receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

During Stage 1 of the Resident Quality Inspection, a family member of Resident #23 stated the resident's teeth look as though they might not have been cleaned.

Resident #23 was observed on May 13, 2015 approximately 1000 hours and the Resident's teeth were observed to be in poor condition and appeared unclean.

Resident #23's current care plan states staff are to complete mouth care morning, evening and after meals.
Resident #23's observational flow sheets was reviewed and it indicates that mouth care was provided once on the day shift of May 1, 2015 and then no mouth care was documented again until the day shift of May 6, 2015 and again on the evening shift . Mouth care was then documented to have been completed once on May 7, 8, 9, 2015 and was not documented to have been completed again until the night shift of May 12, 2015.

PSW staff member #S112 stated during an interview on May 12, 2015 that it is difficult to perform mouth care for Resident #23 as the Resident can be uncooperative. PSW #S112 stated that mouth care is usually completed approximately three times per week for Resident #23. PSW staff member #S108 states Resident #23 will usually accept mouth care if not too lethargic. PSW #S108 indicated using a green swab with a sponge tip dipped in mouthwash to clean the resident's mouth as a toothbrush is not appropriate. PSW staff member #S113 states she uses a toothbrush to provide mouth care to Resident #23 and that the resident will spit into the sink. PSW #S113 states the resident will usually accept mouth care if not too lethargic. When asked if Resident #23 has any noted tooth sensitivity when using a toothbrush, staff member stated no.(541) [s. 34. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 89(1)(a)(iv) whereby there are no procedures developed and implemented to ensure that there is a process to report and locate residents' lost clothing and personal items.

On May 12, 2015, Resident #13 reported to inspector #531 that a pair of pants had gone missing about three or four months ago and had not been found.

On May 12, 2015, Resident #34 reported to inspector #531 that a pair of pants and a blouse went missing about a year ago and that it was reported to staff members #S114 and #S115 in the laundry department. The staff members looked for the missing items, but could not locate them.

On May 13, 2015, PSW #S106 confirmed that there is no procedure developed for locating missing clothing. Staff member #S103 indicated that she would look for the item in the resident's room and the lost and found laundry container located behind the nurses desk.

On May 13, 2015, staff member #S114 was interviewed and stated that there is no procedure developed for locating missing items. She confirms that twice a year the home sets up tables of lost clothing for residents' and families to go through to assist in locating missing items.

On May 13, 2015, RN #S103 confirmed that she would add the lost item of clothing to the

twenty four hour report to notify staff. She stated that the missing clothing remains on report for a few days notifying staff and is then removed, leaving no record of the missing item.

On May 12, 2015, Resident #14 told inspector #531 that a lady that does cleaning came into her drawer and took some of her jewelry - a couple of rings. The resident told the staff member to give it back but she no longer works in the home. The resident reported it to staff and they said they would try to get the rings back but were unable. This occurred about a year ago.

On the same date, Resident #27 told inspector #531 that one of the staff was assisting him with tidying his closet a few months back and he realized that his brand new, red electric razor and battery were missing. He told a PSW and nurse, who said they'd looked for it, but did not locate it.

On May 12, 2015, PSWs S#112 and #S107 were interviewed and confirmed that their responsibility would be to tell the nurse that a resident had reported valuable property missing including money. They were not aware of what the nurse in charge does with the information.

On May 12, 2015, during an interview with RPN #S100 and RN #S103, they confirmed that if they could not resolve the concern they would notify the family, document in the progress notes and write a note for the Director of Care and slide it under her door. Neither were aware of a policy or procedure for reporting missing personal items.

The Administrator was interviewed on May 12, 2015 and confirmed that a report was not received for the missing property of Residents #14 and #27.

On May 13, 2015, the Administrator confirmed that the home does not have procedures developed and implemented to ensure that there is a process to report and locate residents' lost clothing and personal items and is not aware that the corporate office has a procedure for this purpose. [s. 89. (1) (a) (iv)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 97(1)(b) in that a resident's substitute decision-maker (SDM) was not notified within 12 hours upon becoming aware of an alleged, suspected or witnessed incident of abuse of a resident.

The following finding is in relation to log #O-001892-15.

The health care record and a Critical Incident for Resident #29 indicates that the Resident has multiple diagnoses including dementia and requires some assistance for the activities of daily living.

On a specified date, PSW #S126, PSW #S127 and RPN #S123 reported to RN #S125 that a family member of Resident #28 had expressed concerns about the rough care provided by PSW #S129 for Resident #28 and Resident #29 while assisting them to prepare for bed.

In an interview on May 20, 2015, the Administrator confirmed that she did not notify the SDM of Resident #29 of the investigation as she did not have confirmation of improper care. She acknowledged that the SDM of Resident #29 should have been notified of the investigation. [s. 97. (1) (b)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 97(2)in that a resident's substitute decision-maker (SDM) was not notified of the results of an abuse investigation.

The following finding is in relation to log #O-001892-15.

In an interview on May 19, 2015, the SDM of Resident #28 noted that after reporting some concerns about rough care provided by PSW #S129 on a specified date, the family member was assured by the Administrator that an investigation would be undertaken by the home. Although the family member was reassured by this action, he/she indicated not receiving any further information about the results of the investigation.

In an interview on May 20, 2015, the Administrator confirmed that she did not inform the SDM of Resident #28 of the outcome of the investigation immediately after its completion. [s. 97. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 116 (1) whereby the licensee did not ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

On May 14, 2015, the Administrator provided a copy of the Omni Health Care Policy/Program Evaluation that contains the annual evaluation of the medication management system for 2014. She confirmed that the home's Registered Dietitian was not included in the evaluation of the system as part of the interdisciplinary team, as she was not aware of the requirement. [s. 116. (1)]

Issued on this 29th day of May, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PATTISON (197), AMBER MOASE (541), BARBARA ROBINSON (572), SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2015_347197_0019
Log No. / Registre no:	O-001981-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 6, 25, 2015
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	MAPLEWOOD 12 MAPLEWOOD AVENUE, BOX 249, BRIGHTON, ON, K0K-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rachel Corkery

To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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 Resident #31's restraint is assessed and that a monitoring system is immediately implemented to ensure the resident's safety. The monitoring system shall remain in place until an appropriate restraint can be obtained and utilized safely, according to manufacturer's instructions.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 110 (1) in that a physical restraint was altered and not applied according to manufacturer's instructions.

On April 6, 2015 at approximately 1400 hours, Inspector #541 observed Resident #31 in the hallway on the way to an activity. The Resident's restraint was observed to be improperly applied at this time. The Resident was in the presence of staff until the activity was finished at approximately 1520 hours. Inspector #541 observed Resident #31 at 1520 hours and the Resident's restraint remained improperly applied and the Resident had started to take on an unsafe position. Inspector #572 also observed and confirmed the observations. Resident #31 indicated to Inspector #541 that she could not undo the restraint and that she will at times move around.

Inspectors #541 and #572 asked a restorative aide if Resident #31's restraint was appropriately applied and the staff member indicated being unaware of how

to appropriately assess the application of the restraint and that it is determined by a technician. Inspectors then asked a Physiotherapy Assistant if Resident #31's restraint was appropriately applied and this staff member also indicated being unaware of how to appropriately assess the application of the restraint.

The Registered Practical Nurse (RPN), staff member #S100, was asked to observe Resident #31's restraint. The RPN stated that it appeared to not be applied properly, but was unsure of how to appropriately assess the application of the restraint. The RPN then assisted Resident #31 to adjust position at this time, as the resident had started to move.

Inspector #541 approached the Administrator, who then observed Resident #31's physical restraint and confirmed that it was improperly applied and noted there were zip ties applied which were not in accordance with manufacturer's instructions.

When asked how Resident safety is ensured when restraints are applied, the Administrator stated that hourly checks are performed to ensure appropriate application. The Administrator stated that the expectation is for all staff who monitor restraints is to be capable of determining safe application, in accordance with manufacturer's instructions. (541)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall ensure that all staff who apply or monitor restraints are trained in the safe application and use of these devices, including the potential dangers improper application.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 221(1)5 in that training related to the application of restraints has not been provided for staff who apply physical devices or who monitor residents restrained by a physical device.

On May 6, 2015, Inspector #541 observed Resident #31 in the hallway on the way to an activity at approximately 1400 hours. The Resident's restraint appeared improperly applied, however, the resident was with a staff member. When the activity was completed at approximately 1520 hours, Inspector #541 observed Resident #31 again and the was still improperly applied. Inspector #572 was also present and confirmed the observations. Resident #31 was asked if able to undo the restraint, to which the Resident replied "no". Inspector

#541 asked Resident #31 if he/she ever changes position and the Resident replied "yes".

Inspectors #541 and #572 asked a restorative aide, a physiotherapy assistant and the RPN #S100 if they were aware of how Resident #31's restraint is to be applied and all were unaware of how to appropriately assess the application of the resident's restraint.

Inspector #541 approached the Administrator who then observed Resident #31's restraint and confirmed that it was in fact improperly applied and noted there were zip ties which were not in accordance with manufacturers' instructions.

On May 6, 2015, Inspectors #541 and #572 observed Resident #41 with a restraint applied improperly. The Administrator was immediately notified and confirmed that one part of the restraint was secure and positioned appropriately, but acknowledged that another was improperly applied and became more so when the resident moved. The Director of Care confirmed that the secure and properly applied restraint would be in place whenever the other was utilized to ensure the safety of Resident #41 until a new restraint could be applied. The restraint was replaced for Resident #41 on May 7, 2015.

When asked how resident safety is ensured when restraints are applied, the Administrator stated that hourly checks are performed to ensure safety. The Administrator stated the expectation is that all staff who monitor restraints to be capable of determining safe application.

On May 11, 2015, PSW #S109 was asked by Inspector #541 how to determine if a particular restraint is properly applied. The PSW stated that personally, if able to put three fingers between the resident and the restraint, it will not be too tight. When asked why this method, the PSW stated that this was standard knowledge. When asked if the home provides education related to the restraint, the PSW replied yes.

On May 12, 2015, Inspector #541 asked PSW #S108 how a particular restraint is to be applied. The PSW indicated ensuring the Resident's back is against the chair and fits two fingers between the restraint and the Resident. When asked if the home provides education on the safe application of restraints, the PSW replied that there is online education, as well as in-services provided by the home.

PSW #S106 was asked how a particular restraint is appropriately applied. The PSW indicated that one hand can fit in between the resident and the restraint. PSW #S106 was asked how the home provides education on the safe application of restraints and stated the home provides education at the start of shift, as well as in-services.

On May 12, 2015, Inspector #541 asked the Administrator for a copy of the education provided to staff regarding the safe application of physical devices/restraints. The Inspector was provided with policy #CS-5.6 Restraint Monitoring as well as a sheet signed by staff between May 6-7, 2015 to indicate they had reviewed this policy. On May 14, 2015, Inspector reviewed policy #CS-5.6 and it did not contain information on the safe application of physical devices. The Inspector reviewed the policy with the Administrator who confirmed that this was the education provided to staff related to seat belt application. (541) (197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 05, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 6th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Pattison

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