Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 3, 2017	2017_689586_0007	024310-17	Resident Quality Inspection

Licensee/Titulaire de permis

CANADIAN REFORMED SOCIETY FOR A HOME FOR THE AGED INC.
337 STONE CHURCH ROAD EAST HAMILTON ON L9B 1B1

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

MOUNT NEMO CHRISTIAN NURSING HOME
4486 Guelph Line BURLINGTON ON L9T 2X6

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

JESSICA PALADINO (586), DIANNE BARSEVICH (581), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 24, 25, 26 and 27, 2017.

The following CIS inspection was completed concurrently with the RQI -023236-17

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Instrument Assessment (RAI) Co-ordinator, Maintenance Supervisor, Life Enrichment Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspectors reviewed resident health records, medication incident investigation notes, audits, policies and procedures, and internal investigation records, interviewed staff and observed resident care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **2 VPC(s)**
- **3 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 LTCHA, 2007, s. 76. Training

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training the areas set out in the following paragraphs, at times or at intervals provided for in the regulation: 1. Abuse recognition and prevention.

According to the Regulations under section 221, subsection 2 (1), the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

The DOC confirmed that only 14.3 percent (%) of staff completed mandatory annual abuse training in 2016.

2. The licensee failed to ensure that direct care staff were trained on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining that were out in the Act and Regulations.

A request was made for the home's training records related to the minimizing of restraining for resident and how to restrain residents. The DRC provided a record which indicated that restraint education was provided to direct care staff on January 20, 2016. This record identified that 12 staff or 26 percent, of direct care, staff received training on restraints in 2016. The DRC verified that there was no additional training provided on the minimizing of restraining for residents or how to restrain residents in 2016. [s. 76.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices were identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada). The document included: the decision to use, continue to use, or to discontinue the use of a bed rail would be made within the context of an individual resident assessment using an interdisciplinary team with input from the resident or the residents substitute decision-maker (SDM). The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective. Other questions to be considered would be the resident's medical status, behaviors, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether it passed or failed zones one through four). Consideration of these factors would more accurately guide the assessor in making a decision, with either the resident or by the resident's SDM about the necessity and safety of a bed rail. The final conclusion would then be documented on a form (electronically or

on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A. During the RQI, resident #002 was observed in bed with bed rails raised. Review of the plan of care identified they required the use of the bed rails. Interview with the Maintenance Supervisor stated that the residents' bed systems were evaluated in September 2014 to determine whether they passed or failed zones one through four; however stated that if there were any changes made after that date to the bed rails or mattresses, they would visualize the rails and apply pressure to the mattresses to look for any gaps and document this assessment in the bed entrapment test results binder. Review of the home's audit in March 2017, noted for all residents the type of bed and mattress, size of the rails and where the rails were placed on the bed and if the bed system passed or failed but did not include the specific documentation regarding zones one through four. They stated that resident #002's bed systems had not been evaluated with the required weighted equipment to ensure accuracy when testing bed rails and had only been visually tested to determine if the bed system passed zones one through four.

The home failed to ensure that when bed rails were used, their bed system was evaluated to minimize the risk.

B. During the RQI, resident #001's bed system was observed with bed rails raised. Review of the plan of care identified they required the use of the bed rails. Interview with the Maintenance Supervisor identified that the residents' bed systems were evaluated in September 2014, to determine whether they passed or failed zones one through four; however, stated that if there were any changes made after that date to the bed rails or mattresses, they would visualize the rails and apply pressure to the mattresses to look for any gaps and document this assessment in the bed entrapment test results binder. Review of the home's bed entrapment audits identified that the resident's bed system had not been evaluated with the required weighted equipment to ensure accuracy when testing bed rails and had only been visually tested to determine if the bed system passed zones one through four.

The Maintenance Supervisor stated that none of the resident's bed systems have been tested with the required weighted equipment since the initial testing in September 2014, and confirmed that the home has changed mattresses, purchased new beds and changed bed rails since that time. The home indicated that they were strongly looking

into purchasing the appropriate testing supplies and equipment to test all the bed systems.

The home failed to ensure that when bed rails were used, their bed system was evaluated to minimize the risk. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was protected from abuse.

According to Ontario Regulation 79/10, the definition of physical abuse included as follows:
"the use of physical force by anyone other than a resident that causes physical injury or pain".

On an identified date in 2017, while PSW's #104 and #106 were providing care, PSW #106 physically abused resident #030, resulting in injury.

The resident was interviewed about the incident and confirmed that the PSW injured them. The PSW was disciplined as a result.

According to the home's internal investigation notes and interview with the DOC on October 26, 2017, it was confirmed that the incident occurred and that resident #030 was not protected from physical abuse by PSW #106. PSW #106 was disciplined as a result of the incident. [s. 19. (1)]

Additional Required Actions:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the requirements for restraining of a resident by a physical device under section 31 or 36 of the Act, was applied by staff in accordance with any manufacturer's instructions.

During the RQI, resident #003 was observed seated in a wheelchair with a specific restraint in place, that appeared to be applied incorrectly. Review of the manufacturer's instructions provided specific information on how the restraint was to be applied. Review of the plan of care identified they required the specific intervention as a restraint. Interview and observation of the restraint with PSW #100 and #103 confirmed it was not applied correctly and adjusted it appropriately to comply with the manufacturer's instructions. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraining of a resident by a physical device under section 31 or 36 of the Act, is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action was taken as necessary, and a written record was kept of everything required.

The home was asked to provided all medication incident and adverse drug reaction reports for 2017.

A review of the Incident Report book identified that there was only one medication incident, which reached the resident, in 2017.

Resident #040 was involved in a medication incident which was reported the same day. The report did not include a record that the incident was reviewed or analyzed nor was corrective action taken as necessary. The DRC was asked if there was any additional information related to the incident. The DRC identified that there would only be information in the clinical record, related to the incident, as the home had not yet received a further review from pharmacy related to the incident.

Following a review of the clinical record and Incident Report form the DRC confirmed that there was no record that the incident was reviewed or analyzed nor of the corrective action taken. The DRC identified that they did provide re-instruction and education to the RPN who made the error immediately after it was reported; however, there was no documentation of this action. [s. 135. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective action is taken as necessary, and a written record was kept of everything required, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments were integrated, were consistent with and complemented each other.

Resident #003 was observed with a specific restraint in place during the RQI. Review of the MDS assessment and the Restraint Physical Assessment form identified that these were not consistent around the resident's use of the restraint. The DRC confirmed the appropriate use of the restraint with the LTC Inspector. Interview with the RAI coordinator verified that the home coded the specific type of restraints based on previous direction provided to them by the former DRC. The assessments completed were not consistent and did not compliment each other. [s. 6. (4) (a)]

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

A) During the RQI, resident #002 was observed with specific bed rails in place. Review of the Bed Rail Risk Assessment and the written plan of care identified something different than what was observed. Interview with the DRC confirmed the care was not provided to the resident as specified in the plan.

B) During the RQI, resident #003 was observed with a specific falls intervention in place. Interview with PSW #100 confirmed the observation. Review of the written plan of care identified something different than what was observed. Interview with RN #105 confirmed this and acknowledged that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with related to s. 20 (2) (d), the duty under section 24 to make mandatory reports.

The home's policy, "Abuse Prevention – Reporting Abuse or Neglect" (last revised January 2017) directed all staff members who witnessed or suspected the abuse of a resident, or received complaints of abuse, were required to report the matter immediately to their supervisor, the Charge Nurse, Director of Care or the Administrator.

On an identified date in 2017, while PSW's #104 and #106 were providing care, PSW #106 physically abused resident #030, resulting in injury.

The resident was interviewed about the incident and confirmed that the PSW injured them.

i. According to the home's internal investigation notes and interview with PSW #104 on October 26, 2017, it was confirmed that they did not report the incident to the home until the following evening, when RPN #107 asked them about the injury they noted on the resident. The PSW acknowledged that they did not immediately report the incident as per the home's policy.

ii. RPN #107 wrote the incident information in an e-mail that evening and left it under the DOC's office door. The DOC received the information the following morning. The RPN acknowledged that they did not immediately report the incident to the DOC and the home's abuse policy was not complied with. [s. 20. (1)]

2. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports.

Review of the home's policy, "Abuse Prevention – Reporting Abuse or Neglect" (last revised January 2017), directed as follows:

"Any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicions and the information upon which it is based to their Supervisor, the Director of Care or the Administrator:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the home or staff that resulted in harm or risk of harm to the resident.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of resident's money.
5. Misused or misappropriation of funding provided to the Home."

"All staff members, associates, partners and volunteers who witness or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter immediately to their supervisor, the Charge Nurse, Director of Care or the Administrator."

"The following persons are guilty of an offense under the Long Term Care Homes Act: Bill 140, if they fail to make a report required by the legislation:
1. The Home or Director of Resident Care.
2. The Chairman of the Management Committee.
3. Any staff member
4. Any person who provides professional services to a resident in the areas of health, social work or social services work.
5. Any person who provides professional services to the home in the areas of health, social work or social services work"; and,

The home's policy "Abuse Prevention – Investigation Process for Resident Abuse by Formal Caregiver or Volunteer" (last revised January 2017), directed as follows:

"Any staff and volunteers of the Home are required to immediately report alleged/apparent abusive acts that they have witnessed or become aware of."

"The Administrator or designate shall ensure that the incident is reported to the Ministry of Health and Long Term Care within 24 hours".

Interview with RN #105 on October 26, 2017, confirmed that it was the home's expectation that staff report any incidences to the DOC or Administrator. In an interview with PSW #104, they confirmed that they were required to report any incidences to the nurse and that they had never been directed to report to the Director immediately. The DOC acknowledged that the home's policy did not comply with section 24 of the Act that any person had a duty to immediately report the suspicion and the information upon which it was based to the Director. [s. 20. (2) (d)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions.

During the RQI, resident #005 was observed seated in a wheelchair with a specific PASD in place, that appeared to be applied incorrectly. Review of the manufacturer's instructions provided specific information on how the restraint was to be applied. Review of the plan of care identified they required the specific intervention as a restraint. Interview and observation of the restraint with RPN #108 confirmed it was not applied correctly and adjusted it appropriately to comply with the manufacturer's instructions. [s.23].

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

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

The DOC confirmed through interview on October 26, 2017, that the home had no documentation demonstrating that the 2016 abuse program evaluation had been completed. [s. 99. (b)]

Issued on this 3rd day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PALADINO (586), DIANNE BARSEVICH (581), LISA VINK (168)
Inspection No. / No de l'inspection :	2017_689586_0007
Log No. / No de registre :	024310-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 3, 2017
Licensee / Titulaire de permis :	CANADIAN REFORMED SOCIETY FOR A HOME FOR THE AGED INC. 337 STONE CHURCH ROAD EAST, HAMILTON, ON, L9B-1B1
LTC Home / Foyer de SLD :	MOUNT NEMO CHRISTIAN NURSING HOME 4486 Guelph Line, BURLINGTON, ON, L9T-2X6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Plantinga

To CANADIAN REFORMED SOCIETY FOR A HOME FOR THE AGED INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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 :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that all residents, including resident #030, are protected from abuse and neglect.

The licensee shall review and update as needed the home's prevention of abuse and neglect policies and procedures to ensure that it complies with regulatory requirements.

The licensee shall refer to CO #002 on details regarding staff education related to the abuse and neglect policies.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (2), in keeping with s.299 (1) of the Regulation, in respect of the actual harm that resident #030 experienced, the scope of one isolated incident, and the Licensee's history of unrelated non-compliance related to abuse.

The licensee has failed to ensure that every resident was protected from abuse.

According to Ontario Regulation 79/10, the definition of physical abuse included as follows:
"the use of physical force by anyone other than a resident that causes physical injury or pain".

On an identified date in 2017, while PSW's #104 and #106 were providing care, PSW #106 physically abused resident #030, resulting in injury.

The resident was interviewed about the incident and confirmed that the PSW injured them.

According to the home's internal investigation notes and interview with the DOC on October 26, 2017, it was confirmed that the incident occurred and that resident #030 was not protected from physical abuse by PSW #106. PSW #106 was disciplined as a result of the incident. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 76. Training

Order / Ordre :

The licensee shall ensure that all direct care staff are provided training on abuse recognition and prevention, and minimizing of restraining.

The training must include examples from this report to instruct staff on how they are to comply.

There shall be a record of the training provided to each employee. This record shall include the date that the training was completed, topics covered and who/how the training was completed.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (2), in keeping with s.299 (1) of the Regulation, in respect of the risk of harm toward the residents, the scope of a pattern, and the Licensee's history of unrelated non-compliance related to staff training.

The licensee has failed to ensure that all staff who provide direct are to residents received, as a condition of continuing to have contact with residents, training the areas set out in the following paragraphs, at times or at intervals provided for in the regulation: 1. Abuse recognition and prevention.

According to the Regulations under section 221, subsection 2 (1), the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

The DOC confirmed that only 14.3 percent (%) of staff completed mandatory annual abuse training in 2016.

2. The licensee failed to ensure that direct care staff were trained on how to minimize the restraining of residents and how to restrain residents in accordance with the requirements for restraining that were out in the Act and Regulations.

A request was made for the home's training records related to the minimizing of restraining for resident and how to restrain residents. The DRC provided a record which indicated that restraint education was provided to direct care staff on January 20, 2016. This record identified that 12 staff or 26 percent, of direct care, staff received training on restraints in 2016. The DRC verified that there was no additional training provided on the minimizing of restraining for residents or how to restrain residents in 2016. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

The licensee shall complete the following:

1. Re-evaluate all of the bed systems in the home in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006"and document the results. At a minimum, documentation shall include type of mattress and unique mattress identifier, bed rail type, bed frame serial number, date evaluated, name of evaluator, zones tested, issues identified and follow up action taken if necessary.

2. Develop an assessment tool related to bed rail use and bed safety assessments to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006".

3. Amend the home's bed rail policies and associated procedures to include all of the above noted requirements, including documentation of when future assessments are required and the process for staff to follow when assessments are requested.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (2), in keeping with s.299 (1) of the Regulation, in respect of the risk of harm toward the residents, the scope of a widespread issue, and the Licensee's history of unrelated non-compliance related to bed rail entrapment.

The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices were identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug

Administration and adopted by Health Canada). The document included: the decision to use, continue to use, or to discontinue the use of a bed rail would be made within the context of an individual resident assessment using an interdisciplinary team with input from the resident or the residents substitute decision-maker (SDM). The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective. Other questions to be considered would be the resident's medical status, behaviors, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether it passed or failed zones one through four). Consideration of these factors would more accurately guide the assessor in making a decision, with either the resident or by the resident's SDM about the necessity and safety of a bed rail. The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A. During the RQI, resident #002 was observed in bed with bed rails raised. Review of the plan of care identified they required the use of the bed rails. Interview with the Maintenance Supervisor stated that the residents' bed systems were evaluated in September 2014 to determine whether they passed or failed zones one through four; however stated that if there were any changes made after that date to the bed rails or mattresses, they would visualize the rails and apply pressure to the mattresses to look for any gaps and document this assessment in the bed entrapment test results binder. Review of the home's audit in March 2017, noted for all residents the type of bed and mattress, size of the rails and where the rails were placed on the bed and if the bed system passed or failed but did not include the specific documentation regarding zones one through four. They stated that resident #002's bed systems had not been evaluated with the required weighted equipment to ensure accuracy when testing bed rails and had only been visually tested to determine if the bed system passed zones one through four.

The home failed to ensure that when bed rails were used, their bed system was evaluated to minimize the risk.

B. During the RQI, resident #001's bed system was observed with bed rails raised. Review of the plan of care identified they required the use of the bed

rails. Interview with the Maintenance Supervisor identified that the residents' bed systems were evaluated in September 2014, to determine whether they passed or failed zones one through four; however, stated that if there were any changes made after that date to the bed rails or mattresses, they would visualize the rails and apply pressure to the mattresses to look for any gaps and document this assessment in the bed entrapment test results binder. Review of the home's bed entrapment audits identified that the resident's bed system had not been evaluated with the required weighted equipment to ensure accuracy when testing bed rails and had only been visually tested to determine if the bed system passed zones one through four.

The Maintenance Supervisor stated that none of the resident's bed systems have been tested with the required weighted equipment since the initial testing in September 2014, and confirmed that the home has changed mattresses, purchased new beds and changed bed rails since that time. The home indicated that they were strongly looking into purchasing the appropriate testing supplies and equipment to test all the bed systems.

The home failed to ensure that when bed rails were used, their bed system was evaluated to minimize the risk.
(581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3rd day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

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