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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 22, 2017;	2017_546585_0018 (A2)	021891-17	Resident Quality Inspection

Licensee/Titulaire de permis

LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION
44 HUGHSON STREET SOUTH HAMILTON ON L8N 2A7

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

QUEEN'S GARDEN
80 Queen Street North HAMILTON ON L8R 3P6

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

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LEAH CURLE (585) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance order #003 revised.
Compliance order #004 and #005 rescinded.
Compliance order #006 revised and compliance due date changed from January 15, 2018 to February 15, 2018.
Compliance order #007 revised and compliance due date changed from January 15, 2018 to February 15, 2018.

Issued on this 3 day of January 2018 (A1)

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

Original report signed by the inspector.

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LEAH CURLE (585) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): September 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28 and 29, 2017

The following inspections and inquiries were conducted concurrently with this Resident Quality Inspection (RQI) and any findings are included in this RQI report.

Seven complaint inspections:

log #015052-16 related to personal support services

log #027325-16 related to menu planning and personal support services

log #027860-16 related to responsive behaviours

log #003633-17 related to neglect and continence care

log #009366-17 related to personal support services

log #009442-17 related to staff to resident abuse

log #017838-17 related to housekeeping and personal support services

Nine Critical Incident System (CIS) inspections:

CIS log #007558-16 related to staff to resident abuse

CIS log #019594-16 related to staff to resident abuse

CIS log #020405-16 related to personal support services

CIS log #025214-16 related to responsive behaviours

CIS log #026893-16 related to abuse/duty to protect

CIS log #035311-16 related to abuse and plan of care

CIS log #003313-17 related to staff to resident abuse

CIS log #006920-17 related to staff to resident abuse

CIS log #007308-17 related to staff to resident abuse

One follow-up inspection:

Follow-up log #009157-17 regarding Ontario Regulation (O.Reg.) r. 51.(2) (a) continence care and bowel management

Four inquiries:

CIS log #008555-17 related to abuse/improper care

CIS log #015826-17 related to financial abuse

Complaint log #021474-17 related to resident rights

Complaint log #007464-17 related to staff to resident abuse

During the course of the inspection, the inspector(s) spoke with residents, families, personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the wound care nurse, dietary staff, housekeeping staff, a Registered Dietitian (RD), the Food Service Manager (FSM), Environmental Services Supervisor (ESS), Resident Assessment Instrument (RAI) Coordinator, Physician, Assistant Director of Care (ADOC), Director of Care (DOC), Business Office Manager/Acting Administrator and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed resident care and services, reviewed documents that included but were not limited to: resident clinical health records, policies and procedures, assessment tools, menus, logs, training records, program evaluations, investigation records and employee files.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

- **17 WN(s)**
- **8 VPC(s)**
- **7 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, that actions were taken and outcomes evaluated. 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months, 4. Any other weight change that compromises their health status.

A) Resident #007's plan of care stated they were at nutritional risk. Review of their weight records revealed:

i) In July 2017, they experienced a significant weight loss over one month.
ii) In August 2017, they experienced a significant weight loss over one month.
iii) In September 2017, they experienced a significant weight loss over three months.

Interview with Registered Practical Nurse (RPN) #109 confirmed the resident had experienced recent weight loss and reported the home's expectation was for staff to refer to the Registered Dietitian (RD) when any resident experienced a significant weight change. Their clinical health record was reviewed and no referrals were sent to the RD regarding weight loss in July and August 2017. In September 2017, a referral was sent to the RD. Interview with RD #105 confirmed the resident had not been assessed using an interdisciplinary approach, that actions were not taken and outcomes were not evaluated regarding the significant weight changes.

B) Resident #008's plan of care stated they were at nutritional risk, required a modified diet and assistance with eating. Review of their weight records revealed:

In July 2017, they experienced a significant weight loss over six months. A referral was not sent to the RD until the end of July 2017, and the resident was not assessed by RD #122 until the middle of August 2017.

Interview with RD #105 confirmed the resident was not assessed using an interdisciplinary approach; that actions were not taken and outcomes were not evaluated when the resident experienced significant weight loss.

C) Resident #035's plan of care stated they were at nutritional risk, required a modified diet and assistance with eating. Their weight records revealed:

i) In July 2017, they experienced a significant weight loss over one month.
ii) In August 2017, they experienced further significant weight loss over three months and six months.

Interviews with Personal Support Worker (PSW) #119 and PSW #120 confirmed the resident had a decline in their food intake and weight. Review of the resident's health record revealed referrals for the weight loss were sent to the RD in July and August 2017; however, the resident was not assessed by an RD until a specified date in September 2017. Interview with RD #105 confirmed the resident was not assessed using an interdisciplinary approach; that actions were not taken and outcomes were not evaluated when the resident experienced significant weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Compliance order (CO) #001 from complaint inspection #2017_482640_0003, directed the licensee to ensure that:

1) All residents demonstrating incontinence or a change in continence have an assessment or reassessment completed to include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; and

2) All registered staff are trained on the use of the home's designated continence assessment instrument, including when the assessments and reassessments were to be initiated and action to be taken following the assessment.

Interview with the Resident Assessment Instrument (RAI) Coordinator and Director of Care (DOC) reported the home's clinically appropriate assessment instruments were the Bladder Continence Assessment and Bowel Function Assessment.

A) Review of resident clinical records revealed continence assessments or reassessment were not completed as required.

i) Resident #012's clinical record revealed their most recent Bladder Continence Assessment and Bowel Function Assessment were completed in October 2016, and identified they experienced incontinence. Review of their most recent Minimum Data Set (MDS) assessment, completed in July 2017, identified they still experienced incontinence. Interview with the RAI Coordinator confirmed no clinically appropriate bladder or bowel assessment had been completed since October 2016.

ii) Resident #002's clinical record revealed they experienced bladder and bowel incontinence.

In relation to bladder continence, a MDS assessment completed in May 2017, identified they experienced a specified level of bladder incontinence. A Bladder Continence Assessment completed in June 2017, did not identify their level of bladder continence or potential to retrain or their pattern of incontinence. Their next MDS assessment completed in August 2017 identified they continued to experience the same level of bladder incontinence. The RAI coordinator confirmed the resident had not received a complete bladder continence assessment to identify their potential to retrain or pattern of urinary incontinence.

In relation to bowel continence, a MDS assessment completed in May 2017, identified they experienced a specified level of bowel incontinence. A Bowel Function Assessment, completed in May 2017, also identified they experienced bowel incontinence; however, did not identify potential to retrain or pattern of bowel incontinence. Their next MDS assessment completed in August 2017, identified their bowel incontinence level changed. Interview with the RAI coordinator confirmed the resident did not receive a complete bowel and bladder continence assessment in May 2017, and that a bowel assessment was not completed when the resident demonstrated a change in bowel continence in August 2017.

C) Interviews with RPN #150, RPN #114 and RPN #146 revealed registered staff were not aware of when to complete a Bladder Continence Assessment or Bowel Function Assessment; nor had they received recent education regarding continence assessments.

D) Interview with the DOC reported training on the home's requirements on when and how to conduct continence assessments using the home's continence assessment instruments was provided at non-mandatory registered staff team meetings. The DOC reported the education from the meetings were distributed to registered staff though meeting minutes, e-mails as well as verbal conversations; however, confirmed they were could not verify that all registered staff received the required training as outlined in CO #001.

The above non-compliance was identified during the follow-up inspection of compliance order #001, log #009157-17. [s. 51. (2) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that, where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the residents.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". These are the "Clinical Guidance for the

Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" and "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006", and are considered prevailing practices, which are predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

The "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003", includes a uniform set of basic recommendations for caregivers in long term care facilities to use when assessing their residents' need for and possible use of bed rails. Recommendations include but are not limited to the involvement of an interdisciplinary team in the assessment and approval of an individualized care plan for the resident; a risk-benefit assessment that identifies why other care interventions (alternatives to bed rail use) were not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; inspecting, evaluating, maintaining, and upgrading equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and appropriately match the equipment to patient needs, considering all relevant risk factor. In developing "the assessment", consideration to use or not use bed rails should be based on a comprehensive assessment and identification of the resident's needs, which include comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. Therefore, observation of residents in their bed systems, with and without bed rails, over a period of time is essential in being able to answer a series of questions to determine why bed rails would be needed (either as a restraint or a device to assist with bed mobility and transfers) and if bed rails are a safe option for their use.

Bed rails are classified as medical devices by Health Canada and come with inherent risks or hazards that can be fatal to residents. Hazards include but are not limited to suspension, suffocation, entrapment, skin injuries and entanglement. As such, bed rails must be maintained in a safe condition (as per manufacturer's directions), be tested for zones of entrapment (zones one through four which are specific areas around the bed rail and mattress) or have the entrapment zones mitigated, and the resident must be clinically assessed to determine if they are able to understand and safely use the bed rails to minimize any inherent risks to themselves. The population at risk for entrapment are residents who are elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, and acute urinary retention

that cause them to move about the bed or try to exit from the bed. The absence of timely toileting, position change, and nursing care are factors that may also contribute to the risk of entrapment. The assessment guideline offers examples of key assessment questions that guides decision-making such as risk of falling, sleep habits, communication limitations, their mobility, cognition status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns and other factors.

The assessment guideline also emphasizes the need to document clearly whether alternatives to bed rails were used (soft rails or bolsters, perimeter reminders, reaching pole) and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or their SDM (Substitute Decision Maker) and other interdisciplinary team members, would be made about the necessity and safety of bed rail use for a particular resident and the details documented on a form (electronically or on paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the SDM or resident), the size or type of rail to be applied (rotating assist rail, fixed assist rail, 1/4, 1/2 or 3/4 bed rail), when the rails are to be applied (at night only, when in bed, with staff assistance), how many bed rails (one, two), on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

During this inspection, the licensee's clinical assessments of residents using bed rails was compared to the assessment guidelines and determined to lack several key components as listed below;

A) The licensee's bed safety related policy titled "Bed System Assessment - Policy No: LTC-CA-ON-200-07-22", dated January 2016, did not include any references to the above noted assessment guideline. The DOC was not certain if they had reviewed the assessment guideline and could not confirm whether any of the registered staff were provided with any of the details contained within the guideline.

As part of their overall process in assessing the residents, the registered staff were directed by their policy to use a form titled "Bed System Assessment" (BSA) and the procedures included the need to "complete the form for all newly admitted residents prior to the resident being put to bed for their first night in the home". The direction failed to include the need to assess the resident fully with and without bed

rails over a period of time to determine the risks over benefits. The policy directed the registered staff to "discuss" the risks of using one or more bed rails with the resident and if at the conclusion of the assessment the resident was to use the bed rails, the registered staff were to determine if the bed rail was a restraint or a personal assistance services device. The assessment was to be repeated annually and did not include a need to re-assess residents if a change in status was noted or if the resident's bed system components (bed rail or mattress) were changed.

No guiding information was included in the policy as to how the resident would be assessed for safety risks before going to bed and while in bed. The procedures did not include how long the resident would be observed while in bed (with and without bed rails), the length of time resident's would be monitored with or without bed rails, what alternatives were available for trial before deciding that bed rails were an ideal option and for how long, who would monitor the resident during the day/night and how often, what specific bed safety hazards would be monitored for and subsequently documented and how other team members would participate in assisting the registered staff in making a final decision about the benefits versus the risks of the resident's bed system.

The policy did not include the need to compose an interdisciplinary team that could vary depending upon the nature of the care and service setting and the resident's individual needs. Team members for consideration should include, but are not limited to: personal support workers or care givers, social services, and dietary personnel; physicians (or their designees); physiotherapists, resident; family (or authorized representative); and medical equipment suppliers. Because individuals may differ in their sleeping and nighttime habits, creation of a safe bed environment that takes into account patients' medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team. According to the completed assessments reviewed, an interdisciplinary team approach was not apparent and only included the name of the Registered Nurse (RN) or RPN as the assessor. The Physiotherapist in the home reported that they were not involved in any of the bed safety assessments unless specifically asked by registered staff. PSWs were indirectly involved by conducting "safety checks" when residents were in bed. These checks were described as being a continuous routine check for all residents for situations such as a fall from bed, in bed or awake, restless, agitated, behaviours, strange positioning in bed etc. The PSWs also were tasked at documenting if the resident was repositioned, if they were toileted, had pain etc. The staff roles identified and to what extent their input would assist registered staff in making decisions about the residents' overall bed safety

risks was not included in the bed system policy. Bed safety hazards were not specifically included with the routine checks. The bed system policy did not include specifically what type of bed safety risks or hazards the PSWs should be monitoring.

The policy did not include any information related to alternatives to the use of "hard" bed rails or what options were available to mitigate known entrapment zones. The options are listed in both of the companion documents developed by the FDA listed above.

B) The BSA form, which was required to be completed upon the resident's admission was not designed to document what bed related risks were present at the time of admission and which risk factors were independently observed after admission, after several nights of observation. The BSA form included several relevant questions that the registered staff would ask the resident or SDM during admission, related to a resident's risk factor of possibly becoming injured and they included level of mobility, understanding the use of a call bell, awareness of safety issues when getting up from bed, unresolved pain, skin integrity, history of falls, skin tear/bruise or getting a body part caught in a bed rail and history of climbing over a bed rail. No questions were included that identified what resident characteristics and risk factors were present after admission, once the resident was observed in bed with bed rails in place. Examples of questions to assist decision making around the hazards of bed rail use include but are not limited to sleeping habits (if the resident was restless, frequently exited the bed, had a sleep disorder, hallucinations, delirium, slept next to a rail, or along edge of bed), if body parts went through the rail, if the resident understood the purpose of the bed rail or knew how to apply it independently, if the resident knew how to use other bed related components such as a bed remote, the residents' cognition status, involuntary body movements, body size, communication abilities, behaviours that would increase risk of falling or bed entrapment, suspension or injury, history of bed entrapment.

The BSA form included an "alternatives" section for the registered staff to complete, however if the form was to be completed before the resident spent the first night in bed, the only options available to the registered staff would be limited to those that could be implemented ahead of time. The options included a number of fall prevention-related interventions such as a high/low bed, floor mats beside the bed, bed alarm, assistive devices within reach, call bell within reach, timed scheduled toileting and increased safety checks. No true alternative options were

listed to the use of a "hard" bed rail such as perimeter reminders, positioning rolls, roll guards, defined perimeter mattress covers or soft rails/bolsters. The alternatives would need to be implemented and trialled for a period of time to determine if it met the resident's needs and the outcome documented. The BSA form did not include the option to document outcomes.

C) During the tour of the home in two home areas, observations were made that approximately 50 percent of resident beds had at least one bed rail applied, either a half length, three quarter length or rotating assist rail in the guard position (centre of bed). According to one registered staff member and one PSW, the PSWs were required to put the bed rails down when the beds were made. The signs that were posted above each resident's bed, indicating the number of bed rails to apply did not include when to apply the bed rails. The resident's plan of care for many of the residents reviewed did not include when to apply the bed rails and only some included "when in bed".

A random selection of residents were chosen for review, some who were observed in bed at the time of inspection. Although not all of these residents occupied their beds at the time of the observation, the residents either had a sign above their bed or a written plan of care identifying that PSWs were to apply bed rails. To confirm whether residents were assessed in accordance with prevailing practices, the following resident's records were reviewed;

i) Resident #048's bed system was observed on a specified date in September 2017. The bed system included a therapeutic surface with bed rail(s) elevated without any accessories in place to mitigate any entrapment zones. The therapeutic surface was soft and compressible. The resident's written plan of care included they were to have bed rail(s) in the upright position to enhance bed mobility and promote security. At the same time, the plan noted under a different area that they required staff assistance for bed mobility, turning and repositioning. Based on the information, a conclusion could be made that the resident was not able to use the bed rail(s) and therefore would not require them to be implemented. The plan of care also included the resident had a therapeutic surface for areas related to skin integrity, falls and medication use.

The resident's BSA form was completed in June 2017. RPN #101 documented "no" to the question asking if the resident had a therapeutic bed system and "no" to whether the resident had skin integrity issues. The RPN documented that the bed system passed all 4 zones of entrapment, when the bed system did not pass zones

2-4 when evaluated by the Environmental Services Supervisor (ESS) on a specified date in October 2016. The RPN specified the resident's mobility status; that they had a history of falls and determined that the resident would use side rail (s) for bed mobility and repositioning. The resident's progress notes did not include any references to their bed safety status and when their therapeutic surface was implemented and why. No alternatives were documented as trialled before applying the bed rail(s). Interventions listed on the BSA form included call bell within easy reach, toileting and required items within reach.

A risk over benefit assessment was not completed. The decision to apply the bed rail(s) was not based on all of the risk factors and the registered staff did not take into consideration the risks associated with a soft therapeutic surface and incorrectly identified that it had passed entrapment testing.

ii) Resident #049 bed system was observed on two specified dates in September 2017. The bed system included a therapeutic surface with bed rail(s) elevated. The surface was soft and easily compressed and no accessories were noted in and around the bed rail(s). The resident's clinical record identified the resident was provided the therapeutic surface in April 2017 for skin integrity issues.

In September 2017, RPN #144 documented on the BSA form that the resident did not have skin integrity issues, did not have a therapeutic surface and the bed system passed all 4 zones of entrapment. The bed system did not pass zones 2-4 when evaluated by the ESS on a specified date in April 2017. Their written plan of care, under the Bed Rail focus, included that the bed rail(s) were to be up at all times when the resident was in bed to aid with turning and repositioning and that the resident was able to use the bed rail(s). Based on the Bed Mobility focus, the resident required staff assistance to be repositioned. Based on these two focuses, it therefore can be established that the resident did not require bed rail(s) without staff presence. An additional risk factor identified on the resident's plan of care and included on the BSA form was a risk of falling. The BSA form included a comment that the resident and/or SDM chose to have the bed rail(s) elevated. No progress notes could be found to indicate why the therapeutic surface was in place and whether any bed safety risks were evaluated.

A risk over benefit assessment was not completed. The decision to apply the bed rail(s) was not based on all of the risk factors and the registered staff did not take into consideration the risks associated with a soft therapeutic surface, incorrectly identified the mattress type and that it had passed entrapment testing.

iii) Resident #043's bed system was observed on a specified date in September 2017. The resident was not in bed and bed rail(s) were elevated. Their written plan of care included the need to have bed rail(s) elevated when in bed and no reason was provided. The BSA, dated in September 2017, was blank. The resident was not assessed in accordance with prevailing practices prior to the application of one or more bed rails.

iv) Resident #050 was admitted to the home on a specified date in 2017. On admission, they were transferred to bed and RPN #140 applied bed rail(s). Interview with RPN #140 reported they applied the bed rail(s) as a safety precaution related to prevention of falls. The same day, the resident’s BSA form had been completed by a different RPN. A statement was included that the resident and/or SDM requested that the bed rail(s) be applied. The RPN included that the resident had a history of falling; however, falls prevention interventions had not been documented as trialled and the form included options such as bed alarm, hi low bed and fall mats beside the bed. None of these options were selected. There was no determination if the resident could independently use the bed rail(s) for transfers or repositioning before they were applied or whether they were at risk of entrapment, suspension or injury. The resident’s written plan of care plan had already been partially completed by RN #107 and included information that the resident required assistance from staff for mobility and positioning but did not identify what if any bed rail(s) were required.

For this resident, a proper and full assessment was not completed before the registered staff decided to apply the bed rail(s). The RN did not identify how the resident would benefit from the bed rail(s) independently (whether the resident could use the bed rail(s) without staff assistance), whether the bed rail(s) posed any risks to the resident and whether any alternatives were trialled before the bed rail(s) were applied.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. [s. 15. (1) (a)]

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

of entrapment.

According to the ESS, all bed systems that included a therapeutic surface were not evaluated for bed entrapment zones (one through four) that can develop between the mattress and the bed rail. In keeping with Health Canada guidelines, the ESS determined that nine surfaces in the home were too soft and could not be measured using a specialized tool designed to measure entrapment zones. These bed systems were therefore not documented as "failed", but as "not applicable" or the form was left blank and no further action was taken. According to the Health Canada guidelines, these mattresses, although exempt from the measurement guidelines, are not to be disregarded as a safety risk when used in conjunction with one or more bed rails.

On specified dates in September 2017, resident #006, resident #014, resident #039, resident #040, resident #041, resident #048 and resident #049 were observed in their bed, on a therapeutic surface with bed rail(s) in use. Each of these surfaces were pushed down and noted to be soft and without any reinforced perimeter edge or mitigating accessories in place to reduce the entrapment gaps. None of the seven residents were fully assessed in accordance with prevailing practices for bed safety risks by an interdisciplinary team when each of their assessments were reviewed. [s. 15. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003
The following order(s) have been rescinded:CO# 004

WN #4: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

A) The licensee's policy, "Abuse Free Communities-Prevention, Education and Analysis - Policy No: LTC-CA-WQ-100-05-18", revised July 2016 and provided by the home as a policy included in their Abuse Prevention Program, directed that:

a) "Mandatory reporting by all persons" (i.e. employees, volunteers, family members, Substitute Decision Makers (SDMs), Power of Attorney (POA), Long Term Care Home Staff and Long Term Care Home Operators), who have reasonable grounds to suspect the occurrence of any of the following events, either presently or in the near future are legally obligated to immediately report the suspicion and the information upon which it is based to the regulatory bodies including MOHLTC, Director, Regional Health Authorities, and other provincial licensing/certification authorities including abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident."

Staff did not comply with the above noted direction when PSW #100 received a report of alleged staff to resident abuse by PSW #103 to resident #025 on a specified date in 2017. The DOC submitted a Critical Incident Report (CIR) over 24 hours after an incident occurred. The DOC and the CIR confirmed that the Director was not notified at any time prior to the submission of the CIR; over 24 hours after the allegation of abuse was made.

The above noted non-compliance was identified while inspecting Critical Incident System (CIS) log #003313-17.

b) "All staff and volunteers must participate in the Chartwell's Abuse Prevention

Training Program at orientation and annually thereafter."

Staff did not comply with the above noted direction when the DOC and training documents provided by the home confirmed that 21 of 184 (11%) of staff did not receive training in the above noted areas in the 2016 calendar year.

The above noted non-compliance was identified while inspecting CIS log #007308-17, CIS log #003313-17 and CIS log #006920-17.

B) The licensee's policy, "Abuse Allegations and Follow-Up - Policy No: LTC-CA-WQ-100-50-02", revised July 2016 and provided by the home as a policy included in their Abuse Prevention Program, directed that:

"Abuse reporting is immediate and mandatory. All employees are required to report immediately to their respective supervisor/person in charge of the building when at any time information or knowledge of an allegation of an abuse is received or learned from any person."

The licensee failed to ensure staff complied with the above noted directions when on a specified date in 2017, the DOC and documents provided by the home confirmed that RPN #112 did not immediately report an allegation of staff to resident physical abuse of resident #025 by PSW #103. The DOC confirmed that RN #113 did not immediately upon becoming aware of the allegation, contact the manager on call and did not contact the Ministry through the after-hours pager number. The home notified the Ministry of Health and Long Term Care over 24 hours after staff were made aware of the allegation.

The above mentioned non-compliance was identified while inspecting CIS log #003313-17. [s. 20. (1)]

Additional Required Actions:

(A1)The following order(s) have been rescinded:CO# 005

WN #5: 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 the home protected residents from abuse by anyone and that residents were not neglected by the licensee or staff.

A) The licensee failed to ensure resident #027 was protected from physical abuse when it was reported that PSW #111 used physical force on the resident that caused an injury.

In accordance with O. Reg. 79/10, s. 2(1) physical abuse is defined as "the use of physical force by anyone other than a resident that causes physical injury or pain".

On a specified date in 2017, RPN #140 became aware staff to resident physical abuse between PSW #111 and resident #027. Review of the resident's clinical record and the home's investigation notes revealed that the home did not immediately investigate the allegation of physical abuse. The resident's clinical record confirmed they sustained an injury as a result of the altercation.

The licensee failed to protect resident #027 from physical abuse by PSW #111 when the licensee:
1) Failed to immediately investigate an allegation of physical abuse of resident #027 by PSW #111.
2) Failed to ensure that staff complied with the directions contained in the licensee's policies related to the promotion of zero tolerance of abuse and neglect of residents.

3) Failed to ensure that resident #027 received care from staff that only therapeutic in nature and protected the resident from ongoing risk.
4) Failed to ensure that all staff received training in the areas of the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the protections afforded by section 26. Training records provided by the home confirmed that 11% of staff, including PSW #111, did not receive training in the above noted areas in the 2016 calendar year.
6) Failed to ensure that all staff received training in the area of mental health issues, including caring for residents with dementia and behaviour management. Training records provided by the home confirmed that 15% of direct care staff, including PSW #111, did not receive training in the above noted areas in the 2016 calendar year.

The above mentioned non-compliance was identified while inspecting CIS log #006920-17.

B) The licensee failed to ensure that resident #013 was protected from physical abuse.

On a specified date in 2017, resident #013 was physically abused by PSW #135 and sustained an injury. Investigative notes confirmed PSW #135 did not provide resident #013 the care or interventions that they required, which caused resident #013 to sustain a physical injury. Further interviews and investigative notes revealed the licensee failed to protect resident #013 from physical abuse when they:

1) Failed to ensure that PSW #135, understood resident #013's care needs.
2) Failed to ensure that all staff received training in the area of the long-term care home's policy to promote zero tolerance of abuse and neglect in accordance with LTCHA 2007, c. 8, 76 (2) 3. Training records provided by the home confirmed that 11% of all staff had not received training in the above noted area in the 2016 calendar year.
3) Failed to ensure that all staff who provided direct care to resident's received training in the area of Behaviour Management in accordance with LTCHA 2007, c. 8, 76 (7) 3. Training records provided by the home confirmed that 15% of staff who provided direct care to residents had not received training in the above noted area in the 2016 calendar year.
4) Failed to immediately investigate this incident of suspected abuse.

5) Failed to act on measures that were determined to be preventative strategies following the homes investigative of this incident. Investigative notes indicated that a strategy to prevent the situation was to provide PSW #135 with additional training; however, at the time of this inspection the Assistant Director of Care (ADOC) confirmed that PSW #135 had not received the training.

The above mentioned non-compliance was identified while inspecting complaint inspection log #009442-17.

C) The licensee failed to ensure that resident #006 was not neglected by the licensee or staff.

Resident #006's clinical health record was reviewed and revealed the following:

On an identified dates in 2017, staff identified two areas of altered skin integrity on the resident's body. After a period of several weeks, progress notes indicated both areas had worsened. Treatment and interventions were put in place to promote healing; however, the resident's skin condition had deteriorated.

On a specified date in 2017, the Nurse Practitioner (NP) assessed the resident and identified the two areas of altered skin integrity and noted a deterioration in the first area. Two days later, registered staff of the home documented substantial worsening of the first area and noted they had written for staff to call the NP to come and assess the altered skin. No actions were taken after the progress note was made. The next day, the order was changed to increase the frequency of treatment for the first area of altered skin integrity; however, there was no assessment completed and no progress note related to why the treatment was changed.

After the treatment changed, over the course of approximately three weeks, the clinical record revealed treatment for the first area of altered skin integrity was not always provided as per the Treatment Administration Record (TAR). Pain was identified on multiple occasions, including a request for change to the resident's pain management interventions. Pain assessments were not completed when required; nor were weekly head to toe assessment as required by registered staff. A second area of altered skin integrity was identified in a location near the first area. Documentation on the status of the first area of altered skin integrity occurred on three occasions, which revealed that skin integrity was worsening; however, no action was taken. Weekly skin assessments completed by registered staff during

the period did not indicate any change or worsening of the first area of altered skin.

At the end of the three weeks, staff documented in the resident's skin condition had worsened, as well as other substantial symptoms associated with deterioration in skin integrity. New treatment was ordered; however, the resident continued to experience pain and discomfort so the home sent the resident to hospital for further assessment. While in hospital, the they were diagnosed with a specified condition and received treatment. Weeks later, they returned to the home with continued direction to treat the specified condition.

The DOC was interviewed and confirmed with the NP that they were not aware of the resident's condition was not called to assess the resident when it was identified by registered staff to have them re-assess the resident. The DOC indicated that the staff should have called the NP and if the NP was not available, should have called the physician on call.

The resident #006's plan of care also indicated that they required additional specified care interventions related to altered skin integrity. Interventions in the written plan of care were reviewed and did not provide clear direction to staff. Observations made on specified dates in September 2017 revealed their additional care needs were not provided, which was confirmed by PSW #104. Interviews with the wound care nurse and DOC confirmed that the resident required the additional care interventions.

Health care records and interviews revealed that the home failed to provide resident #006 with treatment and care they required. There was a pattern of inaction when the staff failed to document the condition of the resident's altered skin when the treatment was changed. The home failed to ensure that resident's skin was assessed and treated when there were signs of change.

The licensee failed to ensure that resident #006 was protected from neglect by the home. [s. 19. (1)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 006

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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received

immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Resident #006 had a history of alteration in skin integrity. On admission, they had no skin issues. Review of their clinical record revealed the following:

On an identified dates in 2017, staff identified two areas of altered skin integrity on the resident’s body. After a period of several weeks, progress notes indicated both areas had worsened. Treatment and interventions were put in place to promote healing; however, the resident's skin condition had deteriorated.

On a specified date in 2017, the Nurse Practitioner (NP) assessed the resident and identified the two areas of altered skin integrity and noted a deterioration in the first area. Two days later, registered staff of the home documented substantial worsening of the first area and noted they had written for staff to call the NP to come and assess the altered skin. No actions were taken after the progress note was made. The next day, the order was changed to increase the frequency of treatment for the first area of altered skin integrity; however, there was no assessment completed and no progress note related to why the treatment was changed.

After the treatment changed, over the course of approximately three weeks, the clinical record revealed treatment for the first area of altered skin integrity was not always provided as per the Treatment Administration Record (TAR). Pain was identified on multiple occasions, including a request for change to the resident's pain management interventions. Pain assessments were not completed when required; nor were weekly head to toe assessment as required by registered staff. A second area of altered skin integrity was identified in a location near the first area. Documentation on the status of the first area of altered skin integrity occurred on three occasions, which revealed that skin integrity was worsening; however, no action was taken. Weekly skin assessments completed by registered staff during the period did not indicate any change or worsening of the first area of altered skin.

At the end of the three weeks, staff documented in the resident’s skin condition had worsened, as well as other substantial symptoms associated with deterioration in skin integrity. New treatment was ordered; however, the resident continued to experience pain and discomfort so the home sent the resident to hospital for further assessment. While in hospital, they were diagnosed with a specified condition and received treatment. Weeks later, they returned to the home with continued

direction to treat the specified condition.

The DOC was interviewed and confirmed with the NP that they were not aware of the resident's condition was not called to assess the resident when it was identified by registered staff to have them re-assess the resident. The DOC indicated that the staff should have called the NP and if the NP was not available, should have called the physician on call. The ADOC was interviewed and confirmed that comprehensive pain assessments should have been completed when the resident experienced increased pain.

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection. [s. 50. (2) (b) (ii)]

2. The licensee failed to ensure that resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

Resident #006's plan of care indicated that they had altered skin integrity and was diagnosed with a specified condition. Interview the Wound Care Nurse indicated the resident required repositioning every two hours. PSW #104 who provided direct care to the resident and RPN #121 confirmed that resident was to be repositioned every two hours.

On specified dates in September 2017, the resident #006 was observed and was not repositioned every two hours. Interview with PSW #104 confirmed the resident had not been repositioned every two hours. Interview with the DOC who confirmed that the resident was to be repositioned every two hours. [s. 50. (2) (d)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 007

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 and ensure that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 there was a written plan of care for each resident that set out the planned care for the resident.

A) On a specified date in 2017, resident #012 experienced a fall and sustained an

injury. Review of progress notes revealed on a specified date, a specified intervention was implemented in relation to treating the injury; however, the written plan of care did not include the intervention until the following month. Interviews with PSW #131 and PSW #132 confirmed the resident had the specified intervention. Interview with the ADOC confirmed the intervention should have been included in the written plan of care when it was implemented as an intervention.

This non-compliance was issued as a result of complaint inspection log #009366-17.

B) Resident #014 required to a specific oral care interventions. As indicated on their TAR, the intervention was to be done by registered staff. PSW #110, who provided direct care to the resident, confirmed the intervention. The written plan of care was reviewed and did not set out the interventions as the planned care for the resident. The DOC was interviewed and confirmed that the intervention was not added to the written plan of care.

This non-compliance was issued as a result of complaint inspection log #017838-17. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A) On two specified dates in September 2017, resident #003 was observed using a specified device. Interview with PSW #106 revealed the device was used as a Personal Assistance Services Device (PASD). Interview with RPN #109 and confirmed that resident's device was considered a PASD. The current written plan of care was reviewed and identified device was used as a restraint; however, in the same written plan of care, the device was documented as being used as a PASD. RPN #109 and the RAI Coordinator confirmed the device was used as a PASD. On a specified date in October 2016, a progress note indicated that the device had changed from a restraint to PASD. RPN #109 confirmed that the written plan of care did not give clear direction to staff related to the use of the device.

B) Resident #006's plan of care indicated they had altered skin integrity, had a specified diagnosis and required continence care. Interview with the wound care nurse indicated they implemented a specified intervention for the resident to prevent further worsening of skin integrity. Review of interventions in the written

plan of care related to continence care and skin integrity did not provide clear direction on how the care was to be provided. On two specified dates in September 2017, the resident was observed and did not receive the care as specified by the wound care nurse. The DOC confirmed that the directions in the written plan of care did not set out clear direction to staff who provided direct care to the resident.

C) The home was equipped with various therapeutic surfaces. According to two of the various manufacturers, the surfaces were to be set to a specified setting prior to cleaning and before and after getting on or off of the surface. Once on the therapeutic surface, the setting was to be re-set to the resident's weight and preference.

i) Resident #014 had a therapeutic surface. On specified dates in September 2017, they were observed on the surface which was set to a specified number. The manufacturer's guidelines were reviewed and revealed the setting was intended for a weight range that the resident did not fall into. No information was available in their written plan of care to identify that they had a therapeutic surface and what the setting the surface was to be at.

ii) Resident #048 had a therapeutic surface. On specified dates in September 2017, the surface was observed and set to a specified number. A legend for the device was reviewed and revealed the setting was intended for a weight range that the resident did not fall into. Their written plan of care identified they had a therapeutic surface but no information was available regarding settings.

iii) Resident #006 had a therapeutic surface. On a specified date in September 2017, the surface was observed and set to a a specified number; however, a legend for the device revealed the surface was not set at a number suitable for the resident's actual weight. Their written plan of care identified that they had a therapeutic surface but no information was available regarding settings.

Three registered staff were asked about the settings for resident #006, resident #014 and resident #048 and whether or not they knew what the settings were supposed to be set at. None of the registered staff were aware and none identified that they routinely monitored or adjusted the settings. When asked if the information was available in the residents' written plan of care, they stated they did not know. Review of all three residents’ written plan of care confirmed that no information about the required settings for each resident was identified. Various PSWs who worked on the home areas where each of these residents resided

stated that it was not their role to check the settings.

The licensee did not ensure that staff were aware of the various manufacturers' requirements for weight and comfort settings for the various types of therapeutic surfaces for each resident by setting out clear directions in the written plan of care. [s. 6. (1) (c)]

3. The licensee failed to ensure that the resident, the resident's substitute-decision maker (SDM), if any, and any other persons designated by the resident or substitute-decision maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On a specified date in 2016, resident #011, who had a history of responsive behaviours including physical aggression, demonstrated physical responsive behaviours toward co-resident #010. Review of the resident #010's clinical record revealed their SDM was not immediately informed of the incident. Interview with the ADOC confirmed resident #010's SDM was not notified immediately and indicated that it was the expectation of the home that staff inform a resident's SDM of an incident immediately.

This non-compliance was issued as a result of complaint inspection #027860-16. [s. 6. (5)]

4. 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) On a specified date in 2016, an order was made for resident #019 to receive a specified nutritional intervention. Review of their clinical health record revealed that a specified date in 2016, they did not receive any of their nutritional intervention as specified in their plan of care; which was confirmed in an interview with the DOC.

This non-compliance was issued as a result of CIS inspection #020405-16.

B) Resident #006's plan of care indicated they had altered skin integrity. One of the interventions in place was for registered staff to complete a head to toe assessment of the resident once a week. Review of their clinical record during a specified month in 2017 revealed staff did not complete the required head to toe assessments for the resident. At the end of the month, staff identified a change in the resident's area skin integrity, and they were sent to the hospital for further

treatment and diagnosed with a specified condition related to the altered skin integrity. 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. [s. 6. (7)]

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 and ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #8: 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 failed to ensure that 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, is complied

with.

A) In accordance with O. Reg. 79/10, s. 68. (2) (a) requires the licensee to ensure that as part of the organized program of nutrition care and dietary services, the program include, the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, policies and procedures relating to nutrition care and dietary services and hydration including a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

The home's policy, "Weights and Heights - Policy No: LTC-CA-WQ-200-04-07", revised November 2014, stated care staff will weigh each resident by the seventh of the month, record the weight in kilograms and the variance on the weight tracking record. If a re-weigh is required as there has been a gain or loss of 2.0 kilograms (kg) from the previous weight, reset the scale and re-weigh the resident. Record the re-weigh and re-weigh variance if applicable. Registered staff will ensure all weights are put into Point Click Care (PCC) by the 10th of the month and initiate referral to the Registered Dietitian by the 12th of each month."

i) Resident #007's clinical record revealed their monthly weight was not entered into PCC in July 2017. Review of the home area's monthly weights record sheet revealed a weight was recorded for the month of July 2017; however, did not specify a date the weight was measured. Review of the July 2017 weight to the June 2017 weight revealed the resident experienced a loss of 7.5 per cent loss over one month and was greater than 2.0 kg. No re-weigh was noted on weight record sheet, which was confirmed in an interview with RPN #109.

B) In accordance with O. Reg. 79/10, s. 114 (2) requires the licensee is to have written policies and protocols for the medication management system.

1. The licensee's policy, "Medication Administration - Policy No: LTC-CA-WQ-200-06-01", revised April 2017, directed that residents may self-administer medications only when specifically ordered by the attending physician in consultation with the team.

Interview with RPN #124 and the ADOC confirmed their medication administration policy was not complied with regarding #009's medication administration regime.

2. The licensee's policy, "Medication Incidents - Policy No: LTC-CA-WQ-200-06-

11", revised January 2017, directed that medication errors are reviewed quarterly by the Pharmacy and Therapeutics Team for quality improvement purposes.

The ADOC confirmed the medication incidents policy was not complied with when during the first quarter of 2017, one of 22 medication incidents was reviewed by the Professional Advisory group and during the second quarter of 2017, 11 of 15 medication incidents were reviewed by the Professional Advisory group. [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 and ensure that 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 is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incidents of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated:

A) The licensee failed to immediately investigate an allegation of physical abuse by PSW #103 toward resident #025 on a specified date in 2017.

PSW #100 confirmed that they received allegation of staff to resident physical abuse between resident #025 and PSW #103. RPN #112 confirmed that they did not investigate the abuse allegation. RN #113 documented that RPN #112 notified them of the incident hours later and the allegation of abuse was not immediately investigated. The DOC confirmed that the incident of alleged physical abuse was not immediately investigated.

This non-compliance was identified while inspecting CIS log # 003313-17.

B) The licensee failed to immediately investigate an allegation of physical abuse by PSW #111 toward resident #027.

On a specified date in 2017, RPN #140 documented that that they identified an injury on resident #027's body. At that time, documentation indicated that staff

were already aware of an allegation that PSW #111 was physically aggressive toward resident #027. Investigation notes provided by the home also revealed the home did not immediately investigate the allegation which was confirmed in an interview with the DOC.

This non-compliance was identified while inspecting CIS log # 006920-17.

C) The licensee failed to immediately investigate an incident of suspected physical abuse of resident #013.

RPN #138 confirmed there was a suspected incident of staff to resident physical abuse between PSW #135 and resident #013 on a specified date in 2017. RPN #138 confirmed they did not investigate the incident and reported it to RN #113. The DOC confirmed RN #113 contacted the DOC by telephone about the incident, but did not investigate the incident. The DOC confirmed that the incident of suspected abuse of resident #013 was not immediately investigated.

This non-compliance was identified while inspecting CIS log #007308-17. [s. 23. (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 and ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007,

c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations.

A) The licensee failed to ensure that Personal Support Worker #103 received the identified mandatory training before performing their responsibilities.

The DOC and documentation provided by the home confirmed that PSW #103 performed their responsibilities in the home and worked 25 subsequent shifts in the home without orientation and that there were no documentation available to demonstrate that this staff person had received the mandatory training in the areas required before performing their responsibilities, specifically:
i) The Residents' Bill of Rights.
ii) The long-term care home's mission statement.
iii) The long-term care home's policy to promote zero tolerance of abuse and neglect of residents
iv) The duty under section 24 to make mandatory reports.
v) The protections afforded by section 26.
vi) The long-term care home's policy to minimize the restraining of residents.
vii) Fire prevention and safety.
viii) Emergency and evacuation procedures.
ix) Infection prevention and control.
x) All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities.

xi) Any other areas provided for in the regulations, including:
1. The following as required in Ontario Regulation (O. Reg. 79/10), s. 218:
The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
Cleaning and sanitizing of equipment relevant to the staff members responsibilities.
2. The following as required in O. Reg. 79/10, s., 219(4)
Hand hygiene, modes of infection transmission, cleaning and disinfecting practices and the use of personal protective equipment.

B) The licensee failed to ensure that all staff received retraining in accordance with O. Reg. 79/10, s. 219 (1) in the areas of the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the protections afforded by section 26.

The DOC and training records provided by the home confirmed that 21 of 184 of staff (11%), identified as all staff in 2016, did not receive retaining in the areas mentioned above in the 2016 calendar year. [s. 76. (2)]

2. The licensee failed to ensure that the persons who had received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Subsection 219. (1) of O. Reg. 79/10 defined intervals for the purpose of subsection 76 (4) of the Act to be completed at annual intervals.

The licensee failed to ensure that all staff were provided annual training related to infection prevention and control.

Review of the home's 2016 staff education record identified that 15% of all staff did not complete annual retraining related to infection prevention and control, which was confirmed by the DOC. [s. 76. (4)]

3. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, additional training in accordance with Long Term Care Homes Act 2007, c, 8,s. 76 (6) 2 and 3 and O. Reg. 79/10, s. 219(1) in the areas of mental health issues, including caring

for a persons with dementia and behavior management.

The ADOC provided a training tracking form "Annual LTC Manual Education: Attendance Tracker", which identified training in the area of responsive behaviours was considered to be mandatory annual training by the home. The 2016 learning needs assessment confirmed that training in the area of Dementia Care and Responsive Behaviours were learning needs identified by staff. The DOC and training documents provided by the home confirmed that 15% of staff identified as providing direct care to residents in 2016 did not receive training in the areas mentioned above in the 2016 calendar year.

The above mentioned non-compliance was identified while inspecting CIS inspection log #007308-17 and CIS log #006920-17.

4. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas of any other areas provided for in the regulations, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations.

Subsection 221. (2) 1. of O. Reg. 79/10 defined intervals for the purpose of subsection 76 (7) of the Act to be completed at annual intervals.

The licensee failed to ensure that all direct care staff were provided training annually, as required under O. Reg 79/10 s. 221. (1), in the area(s) of:
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. All staff who apply physical devices or who monitor residents restrained by physical devices, receive training in the application use and potential dangers of these physical devices.

Review of the home's 2016 staff education records identified that 15% of direct care staff did not receive training related to skin and wound care, continence care and bowel management, pain management, and the application of physical devices, which was confirmed by the DOC.

Interview with PSW #119 and RPN #145 stated the home had not provided training specific to the application physical devices. Review of the home's education

records related to physical devices did not identify specific direction to regarding the application of physical devices. Interview with the ADOC who confirmed education provided to staff did not provide specific direction on the application on physical devices. [s. 76. (7)]

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 and ensure that all staff at the home have received training as required by this section; no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations; persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations; all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 2. Mental health issues, including caring for persons with dementia. 3. Behaviour management. 6. Any other areas provided for in the regulations., to be implemented voluntarily.

WN #11: 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 following requirements were 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.

On a specified date in September 2017, resident #047 was observed in an unsafe position as a result of an improperly applied physical device. Interviews with PSW #119 and RPN #145 were unaware of manufacturer's instructions for the application of the device. Interview with the DOC confirmed the physical device was not applied according to 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 and 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, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that a drug was administered to resident #009 in accordance with the directions for use specified by the prescriber.

Registered staff failed to administer a specified treatment in accordance with the directions from the resident's physician who prescribed the intervention. Resident #009's physician ordered the resident to receive a specified intervention at a specified time(s) along with orders for assessment and monitoring. The DOC, RPN #124 and the MAR for September 2017 confirmed that the resident #009's specified intervention was not administered in accordance with the directions from the prescriber. The September 2017 MAR confirmed that the resident did not receive a regularly scheduled treatment; nor were they monitored as specified in the in the physician's order for the most days in September 2017. [s. 131. (2)]

2. The licensee failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

RPN #124 and the ADOC confirmed that there was no physician's order for resident #009 to self-administer a specified treatment. [s. 131. (5)]

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 and ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber; and no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #13: 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).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A) As part of the infection prevention and control program, the home's policy, "Hand Hygiene Program, Policy No. LTC-CA-WQ-205-02-04", revised December 2016, outlined when hand hygiene was to be performed, which included, but was not limited to: before preparing, handling serving or eating food; after personal body functions; before putting on and after taking off gloves. The policy also identified hand hygiene to be performed when direct care was being provided, also

known as the “four moments of hand hygiene”, which include : 1) before initial contact with the resident or resident environment, 2) before performing aseptic procedure, 3) after body fluid exposure risk; and 4) after resident or resident environment contact.

i) On September 26, 2017, during a breakfast meal service observation, dietary staff #134 touched a soiled cup, wiped their face and mouth with their hand and continued to serve meals and touch food service areas without performing hand hygiene. PSW #119 was observed clearing soiled dishes then serving food to residents without performing hand hygiene. RPN #124 was observed making contact with one resident, then with a different resident's environment, as well as touching the medication cart and medication pouches without performing hand hygiene.

ii) On September 27, 2017, during a lunch meal service observation, PSW #139 was touched and rubbed their nose, then proceeded to touch two residents and provide assistance with eating without performing hand hygiene.

Interview with the FSM who reported staff were required to perform hand hygiene after touching soiled dishes and touching their face. Interview with DOC confirmed the home's expectation was for staff to perform as per the four moments of hand hygiene and confirmed staff did not participate in the implementation of the infection prevention and control program.

B) As part of the home's infection prevention and control program, the home’s policy, "Daily Infection Surveillance, Policy No. LTC-CA-WQ-205-03-02", revised October 2016, instructed registered staff to observe and assess residents for signs and symptoms of possible infection at the beginning of each shift when making rounds.

On September 22, 2017, PSW #123 reported residents on a specified home area had respiratory infections. RPN #124 was interviewed and indicated that there were residents on the unit that had signs and symptoms of respiratory infection. The home was monitoring these residents and recorded signs and symptoms on the Daily Infection Surveillance Tracking sheet on every shift.

Review of the home area's Daily Infection Surveillance Tracking sheet for the week of September 18 - 22, 2017, revealed multiple residents to have at least one symptom of respiratory infection since September 20, 2017. On September 18,

2017, during day shift, multiple residents were identified to have at least one symptom of respiratory infection. On several shifts between September 18 and September 22, 2017, staff did not record symptoms of infection. Symptoms were not documented on September 18, 2017 night shift, September 19, 2017 on all shifts, September 20, 2017 night shift and September 21, 2017 night shift.

On September 22, 2017, at 1050 hours, RPN #124 was interviewed and indicated that there were several residents on the home area that were showing signs and symptoms of respiratory infection. RPN #124 indicated that they did not have a chance to take those residents' vital signs that morning. The RPN indicated that residents listed on the surveillance tracking sheet were on isolation. LTC Homes Inspector #561 walked through the home area to check the rooms where those residents resided and none of these rooms had the Personal Protective Equipment (PPE) available at the door and no droplet precaution signage was placed on the door to indicate that those residents were on isolation. The RPN confirmed that the PPE was not placed at entrance to those rooms.

Interview with the DOC who indicated the home held the huddles on daily basis and they had discussed the daily infection surveillance tracking sheet and they were aware that there were a number of residents on isolation. The DOC indicated that it was an expectation that these residents were monitored, that the PPE be available at their doors and droplet precaution signage be posted on the doors. The DOC confirmed that the registered staff on the unit were to ensure that all of this was in place and reported they were not aware that this was not done. [s. 229. (4)]

2. The licensee failed to ensure that staff on every shift recorded symptoms of infection in residents and took immediate action as required.

On September 22, 2017, PSW #123 reported residents on a specified home area had respiratory infections. RPN #124 was interviewed who indicated there were residents on the unit that had symptoms of respiratory infections and the home was monitoring these residents. RPN #124 stated that symptoms were being recorded on the Daily Infection Surveillance Tracking sheet on every shift.

The Daily Infection Surveillance Tracking sheet was reviewed for the week of September 18-22, 2017. The tracking sheet revealed that staff were not recording symptoms on all shifts. Symptoms were not documented on September 18, 2017 night shift, September 19, 2017 on all shifts, September 20, 2017 night shift and

September 21, 2017 night shift. The RPN confirmed that it was an expectation that the symptoms were being recorded on every shift. The DOC confirmed that symptoms were to be recorded on the Daily Infection Surveillance Tracking on every shift. [s. 229. (5) (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 and ensure that all staff participate in the implementation of the program; and that on every shift symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On a specified date in September 2017, a visible, large stain was observed on resident #014's floor. Housekeeping staff #136 was interviewed and indicated that their duties were to disinfect the toilet and sink, clean the floors, take out the garbage, replenish paper towels and toilet paper; all of which was being done on daily basis. The housekeeping staff indicated that they were aware of the stain on the floor; however, they were not able to remove it, and confirmed that they first observed the stain about one week prior. LTC Homes Inspector #561 was able to scrape parts of the stain.

The home's policy, "Cleaning, Disinfecting and Sterilization - Policy No. LTC-CA-WQ-205-02-01", revised January 2015, indicated that cleaning procedures incorporate the principles of infection prevention and control and there were cleaning schedules in place to ensure that no area or item is missed from routine cleaning. The policy also indicated that a "hotel clean will be maintained in common use areas of the LTC home and that included floors and baseboards needed to be free of stains, visible dust, spills and streaks".

The home failed to ensure that the floor in resident's room was kept clean and sanitary.

The above noted non-compliance was identified while inspecting complaint log #017838-17. [s. 15. (2) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented

Resident #014 had an intervention in their TAR that registered staff on would check that the resident's mobility device was being cleaned once a week. Review of the resident's TARs from August and September 2017 revealed that staff did not sign the TAR regularly to indicate that they had checked whether the mobility device was being cleaned. The DOC indicated that it was an expectation that registered staff sign the TAR and confirmed that it was not completed.

The above noted non-compliance was identified while inspecting complaint log #017838-17. [s. 30. (2)]

WN #16: 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. (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 failed to ensure that the resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23(1) of the Act, immediately upon the completion of the investigation.

A) The home submitted a CIS report under the category of staff to resident physical abuse on a specified date in 2017. This report was related to resident #025 and documents provided by the home indicated that an investigation was initiated on the same day.

B) The home submitted a CIS report under the category of staff to resident physical abuse on a specified date in 2017. This report was related to resident #027 and documents provided by the home indicated that an investigation was initiated on the same day.

C) The home submitted a CIS report under the category of staff to resident verbal abuse on a specified date in 2017. This report was related to resident #013 and documents provided by the home indicated that an investigation was initiated on the same day.

At the time of this inspection, the DOC was unable to provide evidence to confirm that resident #025, resident #027 and resident #013 and/or their SDMs were notified of the outcome of investigations conducted by the home in relation to resident abuse.

The above noted non-compliance was identified while inspecting CIS logs #003313 -17, #006920-17 and #007308-17 respectively. [s. 97. (2)]

WN #17: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident was reported to the resident or the resident's substitute decision maker.

A) The home provided a Medication Incident Report (MIR) for resident #051 that indicated the resident had not received medications ordered by the resident's physician on a specified date in 2017. The resident was to receive identified medication(s) at a specified time; however, when staff were completing the next

medication administration; they noted that the medication(s) the resident was to receive were still in the medication cart and the MAR had been signed indicating the medications had been given at the previous medication pass. The ADOC and the MIR confirmed that the resident or the resident's SDM were not notified of the medication incident.

B) The home provided a MIR for resident #052 that indicated the resident had received the incorrect dose of an identified medication on two dates in 2017. The ADOC and the MIR confirmed that the resident or the resident's SDM were not notified of this medication incident. [s. 135. (1)]

2. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the last review.

A) Medication Incident Reports provided by the home indicated there were a total of 22 medication incidents reported in the first quarter of 2017. The ADOC confirmed that medication incidents are reviewed each quarter at the Professional Advisory Meeting. The ADOC and the minutes of the above noted meeting recorded for the first quarter of 2017, held on April 25, 2017 indicated that one of the 22 medication incidents that occurred in the quarter were reviewed.

B) Medication Incident Reports provided by the home indicated there were a total of 15 medication incidents reported in the second quarter of 2017. The ADOC confirmed that medication incidents are reviewed each quarter at the Professional Advisory Meeting. The ADOC and the minutes of the above noted meeting, recorded for the second quarter of 2017, held on July 25, 2017 indicated that 11 of the 15 medication incidents that occurred in the quarter were reviewed.

The ADOC confirmed that not all medication incidents reported in the first quarter or the second quarter of 2017 were reviewed. [s. 135. (3)]

Issued on this 3 day of January 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LEAH CURLE (585) - (A1)

Inspection No. / No de l'inspection : 2017_546585_0018 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 021891-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Dec 22, 2017;(A1)

Licensee / Titulaire de permis : LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION
44 HUGHSON STREET SOUTH, HAMILTON, ON, L8N-2A7

LTC Home / Foyer de SLD : QUEEN'S GARDEN
80 Queen Street North, HAMILTON, ON, L8R-3P6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Deborah DiMauro

Ontario

Ministry of Health and Long-Term Care

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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

To LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall:

1. Ensure that all residents with the following weight changes, including resident #007, resident #008 and resident #035, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1) A change of 5 per cent of body weight, or more, over one month.
2) A change of 7.5 per cent of body weight, or more, over three months.
3) A change of 10 per cent of body weight, or more, over 6 months.
4) Any other weight change that compromises the resident's health status.

2. Develop and implement processes and schedules for monitoring staff compliance in accordance with the requirements set out in home's Weights and Heights Policy and Dietary Referral policy.

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10.

The non-compliance was issued as a compliance order (CO) due to a severity level of 2 (minimum harm/risk or potential for actual harm/risk) a scope of 3 (widespread) and a compliance history of 4 (ongoing non-compliance with a VPC issued under the same section on June 19, 2015 and a second VPC under the same section on April 21, 2016).

2. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, that actions were taken and outcomes evaluated. 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months, 4. Any other weight change that compromises their health status.

A) Resident #007's plan of care stated they were at nutritional risk. Review of their weight records revealed:

i) In July 2017, they experienced a significant weight loss over one month.
ii) In August 2017, they experienced a significant weight loss over one month.
iii) In September 2017, they experienced a significant weight loss over three months.

Interview with Registered Practical Nurse (RPN) #109 confirmed the resident had experienced recent weight loss and reported the home's expectation was for staff to refer to the Registered Dietitian (RD) when any resident experienced a significant weight change. Their clinical health record was reviewed and no referrals were sent to the RD regarding weight loss in July and August 2017. In September 2017, a referral was sent to the RD. Interview with RD #105 confirmed the resident had not been assessed using an interdisciplinary approach, that actions were not taken and outcomes were not evaluated regarding the significant weight changes.

B) Resident #008's plan of care stated they were at nutritional risk, required a modified diet and assistance with eating. Review of their weight records revealed:

In July 2017, they experienced a significant weight loss over six months. A referral was not sent to the RD until the end of July 2017, and the resident was not assessed by RD #122 until the middle of August 2017.

Interview with RD #105 confirmed the resident was not assessed using an interdisciplinary approach; that actions were not taken and outcomes were not evaluated when the resident experienced significant weight loss.

C) Resident #035's plan of care stated they were at nutritional risk, required a modified diet and assistance with eating. Their weight records revealed:

i) In July 2017, they experienced a significant weight loss over one month.
ii) In August 2017, they experienced further significant weight loss over three months and six months.

Interviews with Personal Support Worker (PSW) #119 and PSW #120 confirmed the resident had a decline in their food intake and weight. Review of the resident's health record revealed referrals for the weight loss were sent to the RD in July and August 2017; however, the resident was not assessed by an RD until a specified date in September 2017. Interview with RD #105 confirmed the resident was not assessed using an interdisciplinary approach; that actions were not taken and outcomes were not evaluated when the resident experienced significant weight loss. (585)

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

Mar 08, 2018

Ontario

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

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

Linked to Existing Order / Lien vers ordre existant: 2017_482640_0003, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

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

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 :

The licensee shall prepare, submit and implement a plan demonstrating how the home will ensure that all residents who are incontinent, including resident #002 and resident #012, receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The plan shall include but not be limited to the following:

1. An audit of residents who experience incontinence to determine which residents have not received a continence assessment.

2. All residents who are identified as experiencing incontinence, including resident #002 and resident #012, receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

3. An education plan which will be developed and implemented to ensure that all registered staff receive direct, face-to-face training on the use of the home's designated continence assessment instruments, including when the assessments and reassessments are to be initiated and action to be taken following the assessment, and record kept of staff participation in training.

4. Processes and schedules be developed and maintained for monitoring registered staff performance in the completion of the assessments for residents who are incontinent, including all required components, which include but are not limited to: identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The plan shall be submitted to Long-Term Care Homes Inspector Leah Curle, via email at Leah.Curle@Ontario.ca by November 24, 2017.

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10.

The non-compliance was issued as a CO due to a severity level of 2 (minimum harm/risk or potential for actual harm/risk) a scope of 2 (pattern) and a compliance history of 4 (ongoing non-compliance with a CO under the same section on April 13, 2017).

2. The licensee failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Compliance order (CO) #001 from complaint inspection #2017_482640_0003, directed the licensee to ensure that:

1) All residents demonstrating incontinence or a change in continence have an assessment or reassessment completed to include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; and

2) All registered staff are trained on the use of the home's designated continence assessment instrument, including when the assessments and reassessments were to be initiated and action to be taken following the assessment.

Interview with the Resident Assessment Instrument (RAI) Coordinator and Director of Care (DOC) reported the home's clinically appropriate assessment instruments were

the Bladder Continence Assessment and Bowel Function Assessment.

A) Review of resident clinical records revealed continence assessments or reassessment were not completed as required.

i) Resident #012's clinical record revealed their most recent Bladder Continence Assessment and Bowel Function Assessment were completed in October 2016, and identified they experienced incontinence. Review of their most recent Minimum Data Set (MDS) assessment, completed in July 2017, identified they still experienced incontinence. Interview with the RAI Coordinator confirmed no clinically appropriate bladder or bowel assessment had been completed since October 2016.

ii) Resident #002's clinical record revealed they experienced bladder and bowel incontinence.

In relation to bladder continence, a MDS assessment completed in May 2017, identified they experienced a specified level of bladder incontinence. A Bladder Continence Assessment completed in June 2017, did not identify their level of bladder continence or potential to retrain or their pattern of incontinence. Their next MDS assessment completed in August 2017 identified they continued to experience the same level of bladder incontinence. The RAI coordinator confirmed the resident had not received a complete bladder continence assessment to identify their potential to retrain or pattern of urinary incontinence.

In relation to bowel continence, a MDS assessment completed in May 2017, identified they experienced a specified level of bowel incontinence. A Bowel Function Assessment, completed in May 2017, also identified they experienced bowel incontinence; however, did not identify potential to retrain or pattern of bowel incontinence. Their next MDS assessment completed in August 2017, identified their bowel incontinence level changed. Interview with the RAI coordinator confirmed the resident did not receive a complete bowel and bladder continence assessment in May 2017, and that a bowel assessment was not completed when the resident demonstrated a change in bowel continence in August 2017.

C) Interviews with RPN #150, RPN #114 and RPN #146 revealed registered staff were not aware of when to complete a Bladder Continence Assessment or Bowel Function Assessment; nor had they received recent education regarding continence

assessments.

D) Interview with the DOC reported training on the home's requirements on when and how to conduct continence assessments using the home's continence assessment instruments was provided at non-mandatory registered staff team meetings. The DOC reported the education from the meetings were distributed to registered staff though meeting minutes, e-mails as well as verbal conversations; however, confirmed they were could not verify that all registered staff received the required training as outlined in CO #001. (585)

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

Jan 15, 2018

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 :

(A1)
The licensee shall complete the following:

1. Immediately re-assess residents #006, resident #014, resident #039, resident #040, resident #041, resident #048 and resident #049 to determine whether a hard bed rail(s) versus an alternative (such as perimeter reminders, positioning rolls, roll guards, defined perimeter mattress covers or soft rails/bolsters) is necessary for either transfers/repositioning or for a sense of security. If the "hard" bed rail(s) has been determined to be the only or "best" option for the resident, the bed system must be mitigated in accordance with "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006".

2. The re-assessments shall be documented as to the outcome of the assessment, who was involved in the assessment, the accessory required to mitigate the entrapment zones, which entrapment zones are being mitigated, what specific accessory is being applied, when the accessory is to be applied, by whom, and who will monitor the application/use of the accessory. A summary of what was implemented for each of the seven residents shall be submitted to Bernadette.susnik@ontario.ca by December 15, 2017.

3. Amend the home's existing "Bed System Assessment" form and process related to resident clinical assessments and the use of bed rails to include additional 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) which is recommended as the prevailing practice for individualized resident assessment of bed rails. The amended form and process shall, at a minimum, include the following:

a. the observation of the resident while sleeping for a specified period of time, to establish their bed mobility habits, patterns of sleep, transfer abilities, behaviours and other relevant risk factors prior to the application of any bed rail(s) or bed system accessory (bed remote control) or alternative to bed rails (bolster, positioning rolls, roll guards); and
b. the observation of the resident while sleeping for a specific period of time,

to establish safety risks to the resident after a bed rail, accessory or alternative has been applied and deemed necessary; and
c. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during a specified observation period.

4. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form and document the assessed results and recommendations for each resident. All registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply the expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006", and 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) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

5. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. The written plan of care shall include at a minimum information about the resident's ability to independently use the bed rail(s) or whether staff supervision is required, why bed rails are being used or applied, how many, on what side of the bed, bed rail type or size and when they are to be applied (when in bed only or at all times).

6. Develop or acquire information fact sheets or pamphlets identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks/hazards of bed rail use, available alternatives to bed rails, how residents are assessed upon admission, how bed systems are evaluated for entrapment zones, the role of both the SDM and licensee with respect to resident assessments and any other relevant information regarding bed safety. The information shall be disseminated to relevant staff, families and residents (if resident is their own POA).

7. Amend the policy titled "Bed System Assessment" dated January 2016, to include additional and relevant information noted in the prevailing practices identified as 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) and at a minimum the policy shall include;

a) details of the process of assessing residents upon admission, after admission and when a change in the resident's condition has been identified and when a change to the bed system has been made to monitor residents for risks associated with bed rail use and the use of any bed related attachments/accessories on an on-going basis; and
b) guidance for the assessors in being able to make clear decisions based on the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
c) alternatives that are available for the replacement of bed rails and the process of trialling the alternatives and documenting their use; and
d) what interventions are available to mitigate any identified bed safety entrapment or injury risks; and
e) the role of the SDM and/or resident in selecting the appropriate device for the resident's unique identified care needs; and
f) the role of and responsibilities of personal support workers with respect to observing residents in bed related to their bed systems (which includes bed rails, bed frame, accessories, mattresses, bed remote control) and associated safety hazards.

8. Provide face to face training to all relevant staff (PSWs, registered staff, OT/PT) who are affiliated with residents and/or their bed systems with respect to the home's amended bed safety assessment policy and procedures, resident clinical assessments, specific staff roles and responsibilities, how to determine if a resident is at risk of entrapment, strangulation, injury or entanglement while in their bed system and the applicable course of action to be taken when safety risks are identified.

Grounds / Motifs :

(A1)
1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10.

The non-compliance was issued as a CO due to a severity level of 2 (minimal

harm/risk or potential for actual harm/risk), a scope of 3 (the number of residents who have not been adequately assessed is widespread) and a compliance history of 3 (ongoing non-compliance with a WN related to bed rail use issued under the same section on April 21, 2016 and a WN related to bed rail use in a similar section on June 19, 2015).

2. The licensee did not ensure that, where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the residents.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". These are the “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" and “A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006”, and are considered prevailing practices, which are predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

The "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003”, includes a uniform set of basic recommendations for caregivers in long term care facilities to use when assessing their residents’ need for and possible use of bed rails. Recommendations include but are not limited to the involvement of an interdisciplinary team in the assessment and approval of an individualized care plan for the resident; a risk-benefit assessment that identifies why other care interventions (alternatives to bed rail use) were not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; inspecting, evaluating, maintaining, and upgrading equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and appropriately match the equipment to patient needs, considering all relevant risk factor. In developing “the assessment”, consideration to use or not use bed rails should be based on a comprehensive assessment and identification of the

resident's needs, which include comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. Therefore, observation of residents in their bed systems, with and without bed rails, over a period of time is essential in being able to answer a series of questions to determine why bed rails would be needed (either as a restraint or a device to assist with bed mobility and transfers) and if bed rails are a safe option for their use.

Bed rails are classified as medical devices by Health Canada and come with inherent risks or hazards that can be fatal to residents. Hazards include but are not limited to suspension, suffocation, entrapment, skin injuries and entanglement. As such, bed rails must be maintained in a safe condition (as per manufacturer's directions), be tested for zones of entrapment (zones one through four which are specific areas around the bed rail and mattress) or have the entrapment zones mitigated, and the resident must be clinically assessed to determine if they are able to understand and safely use the bed rails to minimize any inherent risks to themselves. The population at risk for entrapment are residents who are elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, and acute urinary retention that cause them to move about the bed or try to exit from the bed. The absence of timely toileting, position change, and nursing care are factors that may also contribute to the risk of entrapment. The assessment guideline offers examples of key assessment questions that guides decision-making such as risk of falling, sleep habits, communication limitations, their mobility, cognition status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns and other factors.

The assessment guideline also emphasizes the need to document clearly whether alternatives to bed rails were used (soft rails or bolsters, perimeter reminders, reaching pole) and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or their SDM (Substitute Decision Maker) and other interdisciplinary team members, would be made about the necessity and safety of bed rail use for a particular resident and the details documented on a form (electronically or on paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the SDM or resident), the size or type of rail to be applied (rotating assist rail, fixed assist rail, 1/4, 1/2 or 3/4 bed rail), when the rails are to be applied (at night only, when in bed, with staff assistance),

how many bed rails (one, two), on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

During this inspection, the licensee's clinical assessments of residents using bed rails was compared to the assessment guidelines and determined to lack several key components as listed below;

A) The licensee’s bed safety related policy titled “Bed System Assessment - Policy No: LTC-CA-ON-200-07-22”, dated January 2016, did not include any references to the above noted assessment guideline. The DOC was not certain if they had reviewed the assessment guideline and could not confirm whether any of the registered staff were provided with any of the details contained within the guideline.

As part of their overall process in assessing the residents, the registered staff were directed by their policy to use a form titled "Bed System Assessment" (BSA) and the procedures included the need to “complete the form for all newly admitted residents prior to the resident being put to bed for their first night in the home”. The direction failed to include the need to assess the resident fully with and without bed rails over a period of time to determine the risks over benefits. The policy directed the registered staff to “discuss” the risks of using one or more bed rails with the resident and if at the conclusion of the assessment the resident was to use the bed rails, the registered staff were to determine if the bed rail was a restraint or a personal assistance services device. The assessment was to be repeated annually and did not include a need to re-assess residents if a change in status was noted or if the resident’s bed system components (bed rail or mattress) were changed.

No guiding information was included in the policy as to how the resident would be assessed for safety risks before going to bed and while in bed. The procedures did not include how long the resident would be observed while in bed (with and without bed rails), the length of time resident’s would be monitored with or without bed rails, what alternatives were available for trial before deciding that bed rails were an ideal option and for how long, who would monitor the resident during the day/night and how often, what specific bed safety hazards would be monitored for and subsequently documented and how other team members would participate in assisting the registered staff in making a final decision about the benefits versus the risks of the resident's bed system.

The policy did not include the need to compose an interdisciplinary team that could vary depending upon the nature of the care and service setting and the resident's individual needs. Team members for consideration should include, but are not limited to: personal support workers or care givers, social services, and dietary personnel; physicians (or their designees); physiotherapists, resident; family (or authorized representative); and medical equipment suppliers. Because individuals may differ in their sleeping and nighttime habits, creation of a safe bed environment that takes into account patients' medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team. According to the completed assessments reviewed, an interdisciplinary team approach was not apparent and only included the name of the Registered Nurse (RN) or RPN as the assessor. The Physiotherapist in the home reported that they were not involved in any of the bed safety assessments unless specifically asked by registered staff. PSWs were indirectly involved by conducting "safety checks" when residents were in bed. These checks were described as being a continuous routine check for all residents for situations such as a fall from bed, in bed or awake, restless, agitated, behaviours, strange positioning in bed etc.. The PSWs also were tasked at documenting if the resident was repositioned, if they were toileted, had pain etc.. The staff roles identified and to what extent their input would assist registered staff in making decisions about the residents' overall bed safety risks was not included in the bed system policy. Bed safety hazards were not specifically included with the routine checks. The bed system policy did not include specifically what type of bed safety risks or hazards the PSWs should be monitoring.

The policy did not include any information related to alternatives to the use of "hard" bed rails or what options were available to mitigate known entrapment zones. The options are listed in both of the companion documents developed by the FDA listed above.

B) The BSA form, which was required to be completed upon the resident's admission was not designed to document what bed related risks were present at the time of admission and which risk factors were independently observed after admission, after several nights of observation. The BSA form included several relevant questions that the registered staff would ask the resident or SDM during admission, related to a resident's risk factor of possibly becoming injured and they included level of mobility, understanding the use of a call bell, awareness of safety issues when getting up from bed, unresolved pain, skin integrity, history of falls, skin tear/bruise or getting a body part caught in a bed rail and history of climbing over a bed rail. No questions were

included that identified what resident characteristics and risk factors were present after admission, once the resident was observed in bed with bed rails in place. Examples of questions to assist decision making around the hazards of bed rail use include but are not limited to sleeping habits (if the resident was restless, frequently exited the bed, had a sleep disorder, hallucinations, delirium, slept next to a rail, or along edge of bed), if body parts went through the rail, if the resident understood the purpose of the bed rail or knew how to apply it independently, if the resident knew how to use other bed related components such as a bed remote, the residents' cognition status, involuntary body movements, body size, communication abilities, behaviours that would increase risk of falling or bed entrapment, suspension or injury, history of bed entrapment.

The BSA form included an "alternatives" section for the registered staff to complete, however if the form was to be completed before the resident spent the first night in bed, the only options available to the registered staff would be limited to those that could be implemented ahead of time. The options included a number of fall prevention-related interventions such as a high/low bed, floor mats beside the bed, bed alarm, assistive devices within reach, call bell within reach, timed scheduled toileting and increased safety checks. No true alternative options were listed to the use of a "hard" bed rail such as perimeter reminders, positioning rolls, roll guards, defined perimeter mattress covers or soft rails/bolsters. The alternatives would need to be implemented and trialled for a period of time to determine if it met the resident's needs and the outcome documented. The BSA form did not include the option to document outcomes.

C) During the tour of the home in two specific home areas, observations were made that approximately 50 percent of resident beds had at least one bed rail applied, either a half length, three quarter length or rotating assist rail in the guard position (centre of bed). According to one registered staff member and one PSW, the PSWs were required to put the bed rails down when the beds were made. The signs that were posted above each resident's bed, indicating the number of bed rails to apply did not include when to apply the bed rails. The resident's plan of care for many of the residents reviewed did not include when to apply the bed rails and only some included "when in bed".

A random selection of residents were chosen for review, some who were observed in bed at the time of inspection. Although not all of these residents occupied their beds at the time of the observation, the residents either had a sign above their bed or a

written plan of care identifying that PSWs were to apply bed rails. To confirm whether residents were assessed in accordance with prevailing practices, the following resident's records were reviewed;

i) Resident #048's bed system was observed on a specified date in September 2017. The bed system included a therapeutic surface with bed rail(s) elevated without any accessories in place to mitigate any entrapment zones. The therapeutic surface was soft and compressible. The resident's written plan of care included they were to have bed rail(s) in the upright position to enhance bed mobility and promote security. At the same time, the plan noted under a different area that they required staff assistance for bed mobility, turning and repositioning. Based on the information, a conclusion could be made that the resident was not able to use the bed rail(s) and therefore would not require them to be implemented. The plan of care also included the resident had a therapeutic surface for areas related to skin integrity, falls and medication use.

The resident's BSA form was completed in June 2017. RPN #101 documented "no" to the question asking if the resident had a therapeutic bed system and "no" to whether the resident had skin integrity issues. The RPN documented that the bed system passed all 4 zones of entrapment, when the bed system did not pass zones 2 -4 when evaluated by the Environmental Services Supervisor (ESS) on a specified date in October 2016. The RPN specified the resident's mobility status; that they had a history of falls and determined that the resident would use side rail(s) for bed mobility and repositioning. The resident's progress notes did not include any references to their bed safety status and when their therapeutic surface was implemented and why. No alternatives were documented as trialled before applying the bed rail(s). Interventions listed on the BSA form included call bell within easy reach, toileting and required items within reach.

A risk over benefit assessment was not completed. The decision to apply the bed rail (s) was not based on all of the risk factors and the registered staff did not take into consideration the risks associated with a soft therapeutic surface and incorrectly identified that it had passed entrapment testing.

ii) Resident #049 bed system was observed on two specified dates in September 2017. The bed system included a therapeutic surface with bed rail(s) elevated. The surface was soft and easily compressed and no accessories were noted in and around the bed rail(s). The resident's clinical record identified the resident was

provided the therapeutic surface in April 2017 for skin integrity issues.

In September 2017, RPN #144 documented on the BSA form that the resident did not have skin integrity issues, did not have a therapeutic surface and the bed system passed all 4 zones of entrapment. The bed system did not pass zones 2-4 when evaluated by the ESS on a specified date in April 2017. Their written plan of care, under the Bed Rail focus, included that the bed rail(s) were to be up at all times when the resident was in bed to aid with turning and repositioning and that the resident was able to use the bed rail(s). Based on the Bed Mobility focus, the resident required staff assistance to be repositioned. Based on these two focuses, it therefore can be established that the resident did not require bed rail(s) without staff presence. An additional risk factor identified on the resident's plan of care and included on the BSA form was a risk of falling. The BSA form included a comment that the resident and/or SDM chose to have the bed rail(s) elevated. No progress notes could be found to indicate why the therapeutic surface was in place and whether any bed safety risks were evaluated.

A risk over benefit assessment was not completed. The decision to apply the bed rail (s) was not based on all of the risk factors and the registered staff did not take into consideration the risks associated with a soft therapeutic surface, incorrectly identified the mattress type and that it had passed entrapment testing.

iii) Resident #043's bed system was observed on a specified date in September 2017. The resident was not in bed and bed rail(s) were elevated. Their written plan of care included the need to have bed rail(s) elevated when in bed and no reason was provided. The BSA, dated in September 2017, was blank. The resident was not assessed in accordance with prevailing practices prior to the application of one or more bed rails.

iv) Resident #050 was admitted to the home on a specified date in 2017. On admission, they were transferred to bed and RPN #140 applied bed rail(s). Interview with RPN #140 reported they applied the bed rail(s) as a safety precaution related to prevention of falls. The same day, the resident's BSA form had been completed by a different RPN. A statement was included that the resident and/or SDM requested that the bed rail(s) be applied. The RPN included that the resident had a history of falling; however, falls prevention interventions had not been documented as trialled and the form included options such as bed alarm, hi low bed and fall mats beside the bed. None of these options were selected. There was no determination if the resident

could independently use the bed rail(s) for transfers or repositioning before they were applied or whether they were at risk of entrapment, suspension or injury. The resident's written plan of care plan had already been partially completed by RN #107 and included information that the resident required assistance from staff for mobility and positioning but did not identify what if any bed rail(s) were required.

For this resident, a proper and full assessment was not completed before the registered staff decided to apply the bed rail(s). The RN did not identify how the resident would benefit from the bed rail(s) independently (whether the resident could use the bed rail(s) without staff assistance), whether the bed rail(s) posed any risks to the resident and whether any alternatives were trialled before the bed rail(s) were applied.

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

3. The licensee did not ensure that where bed rails were used, that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

According to the ESS, all bed systems that included a therapeutic surface were not evaluated for bed entrapment zones (one through four) that can develop between the mattress and the bed rail. In keeping with Health Canada guidelines, the ESS determined that nine surfaces in the home were too soft and could not be measured using a specialized tool designed to measure entrapment zones. These bed systems were therefore not documented as "failed", but as "not applicable" or the form was left blank and no further action was taken. According to the Health Canada guidelines, these mattresses, although exempt from the measurement guidelines, are not to be disregarded as a safety risk when used in conjunction with one or more bed rails.

On specified dates in September 2017, resident #006, resident #014, resident #039, resident #040, resident #041, resident #048 and resident #049 were observed in

their bed, on a therapeutic surface with bed rail(s) in use. Each of these surfaces were pushed down and noted to be soft and without any reinforced perimeter edge or mitigating accessories in place to reduce the entrapment gaps. None of the seven residents were fully assessed in accordance with prevailing practices for bed safety risks by an interdisciplinary team when each of their assessments were reviewed. (120)

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

May 31, 2018

(A1)
The following Order has been rescinded:

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

(A1)
The following Order has been rescinded:

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 006

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 :

(A1)
The licensee shall:
1. Protect all residents, including resident #027 and resident #013 from abuse by anyone.
2. Protect all residents, including resident #006 from neglect by the licensee or staff.
3. Provide face to face training for all staff on abuse and what constitutes abuse, including the licensee's policies related to abuse prevention and management of alleged, suspected or witnessed situations of resident abuse and neglect.
4. Develop and implement a system for staff's compliance with the licensee's policies mentioned above.
5. Provide face to face training for all staff on neglect and what constitutes neglect, including the example of neglect identified for resident #006 as it related to skin and wound care.
6. Provide face to face training for staff who provide direct care to residents in areas related to the development and maintenance of therapeutic staff-resident relationships, dementia and the management of responsive behaviours.
7. Maintain all records of the above noted training and participants.

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10.

The non-compliance was issued as a CO due to a severity level of 3 (actual harm/risk) a scope of 2 (pattern) and a compliance history of 4 (ongoing non-compliance with a VPC under the same section on April 21, 2016).

2. The licensee failed to ensure that the home protected residents from abuse by anyone and that residents were not neglected by the licensee or staff.

A) The licensee failed to ensure resident #027 was protected from physical abuse when it was reported that PSW #111 used physical force on the resident that caused an injury.

In accordance with O. Reg. 79/10, s. 2(1) physical abuse is defined as "the use of physical force by anyone other than a resident that causes physical injury or pain".

On a specified date in 2017, RPN #140 became aware staff to resident physical abuse between PSW #111 and resident #027. Review of the resident's clinical record and the home's investigation notes revealed that the home did not immediately investigate the allegation of physical abuse. The resident's clinical record confirmed they sustained an injury as a result of the altercation.

The licensee failed to protect resident #027 from physical abuse by PSW #111 when the licensee:
1) Failed to immediately investigate an allegation of physical abuse of resident #027 by PSW #111.
2) Failed to ensure that staff complied with the directions contained in the licensee's policies related to the promotion of zero tolerance of abuse and neglect of residents.
3) Failed to ensure that resident #027 received care from staff that only therapeutic in nature and protected the resident from ongoing risk.
4) Failed to ensure that all staff received training in the areas of the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the protections afforded by section 26. Training records provided by the home confirmed that 11% of staff, including PSW #111, did not receive training in the above noted areas in the 2016 calendar year.
6) Failed to ensure that all staff received training in the area of mental health issues, including caring for residents with dementia and behaviour management. Training records provided by the home confirmed that 15% of direct care staff, including PSW

#111, did not receive training in the above noted areas in the 2016 calendar year.

The above mentioned non-compliance was identified while inspecting CIS log #006920-17.

B) The licensee failed to ensure that resident #013 was protected from physical abuse.

On a specified date in 2017, resident #013 was physically abused by PSW #135 and sustained an injury. Investigative notes confirmed PSW #135 did not provide resident #013 the care or interventions that they required, which caused resident #013 to sustain a physical injury. Further interviews and investigative notes revealed the licensee failed to protect resident #013 from physical abuse when they:

1) Failed to ensure that PSW #135, understood resident #013's care needs.
2) Failed to ensure that all staff received training in the area of the long-term care home's policy to promote zero tolerance of abuse and neglect in accordance with LTCHA 2007, c. 8, 76 (2) 3. Training records provided by the home confirmed that 11% of all staff had not received training in the above noted area in the 2016 calendar year.
3) Failed to ensure that all staff who provided direct care to resident's received training in the area of Behaviour Management in accordance with LTCHA 2007, c. 8, 76 (7) 3. Training records provided by the home confirmed that 15% of staff who provided direct care to residents had not received training in the above noted area in the 2016 calendar year.
4) Failed to immediately investigate this incident of suspected abuse.
5) Failed to act on measures that were determined to be preventative strategies following the homes investigative of this incident. Investigative notes indicated that a strategy to prevent the situation was to provide PSW #135 with additional training; however, at the time of this inspection the Assistant Director of Care (ADOC) confirmed that PSW #135 had not received the training.

The above mentioned non-compliance was identified while inspecting complaint inspection log #009442-17.

C) The licensee failed to ensure that resident #006 was not neglected by the licensee or staff.

Resident #006's clinical health record was reviewed and revealed the following:

On an identified dates in 2017, staff identified two areas of altered skin integrity on the resident's body. After a period of several weeks, progress notes indicated both areas had worsened. Treatment and interventions were put in place to promote healing; however, the resident's skin condition had deteriorated.

On a specified date in 2017, the Nurse Practitioner (NP) assessed the resident and identified the two areas of altered skin integrity and noted a deterioration in the first area. Two days later, registered staff of the home documented substantial worsening of the first area and noted they had written for staff to call the NP to come and assess the altered skin. No actions were taken after the progress note was made. The next day, the order was changed to increase the frequency of treatment for the first area of altered skin integrity; however, there was no assessment completed and no progress note related to why the treatment was changed.

After the treatment changed, over the course of approximately three weeks, the clinical record revealed treatment for the first area of altered skin integrity was not always provided as per the Treatment Administration Record (TAR). Pain was identified on multiple occasions, including a request for change to the resident's pain management interventions. Pain assessments were not completed when required; nor were weekly head to toe assessment as required by registered staff. A second area of altered skin integrity was identified in a location near the first area. Documentation on the status of the first area of altered skin integrity occurred on three occasions, which revealed that skin integrity was worsening; however, no action was taken. Weekly skin assessments completed by registered staff during the period did not indicate any change or worsening of the first area of altered skin.

At the end of the three weeks, staff documented in the resident's skin condition had worsened, as well as other substantial symptoms associated with deterioration in skin integrity. New treatment was ordered; however, the resident continued to experience pain and discomfort so the home sent the resident to hospital for further assessment. While in hospital, the they were diagnosed with a specified condition and received treatment. Weeks later, they returned to the home with continued direction to treat the specified condition.

The DOC was interviewed and confirmed with the NP that they were not aware of the resident's condition was not called to assess the resident when it was identified by

registered staff to have them re-assess the resident. The DOC indicated that the staff should have called the NP and if the NP was not available, should have called the physician on call.

The resident #006's plan of care also indicated that they required additional specified care interventions related to altered skin integrity. Interventions in the written plan of care were reviewed and did not provide clear direction to staff. Observations made on specified dates in September 2017 revealed their additional care needs were not provided, which was confirmed by PSW #104. Interviews with the wound care nurse and DOC confirmed that the resident required the additional care interventions.

Health care records and interviews revealed that the home failed to provide resident #006 with treatment and care they required. There was a pattern of inaction when the staff failed to document the condition of the resident's altered skin when the treatment was changed. The home failed to ensure that resident's skin was assessed and treated when there were signs of change.

The licensee failed to ensure that resident #006 was protected from neglect by the home. (129)

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

Feb 15, 2018(A1)

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan demonstrating how the home will ensure that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The plan shall include but not be limited to the following:
1. How the home will ensure that resident #006 and other residents with altered skin integrity receive immediate treatment and interventions to promote healing and prevent infection.
2. Processes and schedules to be developed and implemented for monitoring registered nursing staff's performance in completing skin assessments using a clinically appropriate assessment instrument when a resident is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.
3. An auditing process which will be developed in the home to ensure that staff complete treatments for wounds according to the order.
4. When registered staff change wound dressings they document in detail the status and condition of the wound in the resident's clinical health record when there is a change in the condition of the wound.
5. All registered staff are re-trained on skin and wound management, specifically, related to thorough wound assessments, wound referrals as indicated and related documentation. The home shall keep a record of attendance and the education materials.

The plan shall be submitted to Long-Term Care Homes Inspector Daria Trzos, via email at Daria.Trzos@ontario.ca by November 24, 2017.

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10.

The non-compliance was issued as a CO due to a severity level of 3 (actual harm/risk), a scope of 1 (isolated) and a compliance history of 3 (previous non-compliance issued in a similar area on June 19, 2015).

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Resident #006 had a history of alteration in skin integrity. On admission, they had no skin issues. Review of their clinical record revealed the following:

On an identified dates in 2017, staff identified two areas of altered skin integrity on the resident's body. After a period of several weeks, progress notes indicated both areas had worsened. Treatment and interventions were put in place to promote healing; however, the resident's skin condition had deteriorated.

On a specified date in 2017, the Nurse Practitioner (NP) assessed the resident and identified the two areas of altered skin integrity and noted a deterioration in the first area. Two days later, registered staff of the home documented substantial worsening of the first area and noted they had written for staff to call the NP to come and assess the altered skin. No actions were taken after the progress note was made. The next day, the order was changed to increase the frequency of treatment for the first area of altered skin integrity; however, there was no assessment completed and no progress note related to why the treatment was changed.

After the treatment changed, over the course of approximately three weeks, the clinical record revealed treatment for the first area of altered skin integrity was not always provided as per the Treatment Administration Record (TAR). Pain was identified on multiple occasions, including a request for change to the resident's pain management interventions. Pain assessments were not completed when required; nor were weekly head to toe assessment as required by registered staff. A second area of altered skin integrity was identified in a location near the first area. Documentation on the status of the first area of altered skin integrity occurred on three occasions, which revealed that skin integrity was worsening; however, no action was taken. Weekly skin assessments completed by registered staff during the period did not indicate any change or worsening of the first area of altered skin.

At the end of the three weeks, staff documented in the resident's skin condition had worsened, as well as other substantial symptoms associated with deterioration in skin integrity. New treatment was ordered; however, the resident continued to

experience pain and discomfort so the home sent the resident to hospital for further assessment. While in hospital, they were diagnosed with a specified condition and received treatment. Weeks later, they returned to the home with continued direction to treat the specified condition.

The DOC was interviewed and confirmed with the NP that they were not aware of the resident's condition was not called to assess the resident when it was identified by registered staff to have them re-assess the resident. The DOC indicated that the staff should have called the NP and if the NP was not available, should have called the physician on call. The ADOC was interviewed and confirmed that comprehensive pain assessments should have been completed when the resident experienced increased pain.

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

3. The licensee failed to ensure that resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

Resident #006's plan of care indicated that they had altered skin integrity and was diagnosed with a specified condition. Interview the Wound Care Nurse indicated the resident required repositioning every two hours. PSW #104 who provided direct care to the resident and RPN #121 confirmed that resident was to be repositioned every two hours.

On specified dates in September 2017, the resident #006 was observed and was not repositioned every two hours. Interview with PSW #104 confirmed the resident had not been repositioned every two hours. Interview with the DOC who confirmed that the resident was to be repositioned every two hours. (585)

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

Feb 15, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

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

RENSEIGNEMENTS 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

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

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

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 3 day of January 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LEAH CURLE - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Service Area Office / Bureau régional de services : Hamilton