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

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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2017;	2017_619550_0004 (A2)	013528-16	Resident Quality Inspection

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA OTTAWA ON K1C 2Z6

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

JOANNE HENRIE (550) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date was changed from August 31, 2017 to October 13, 2017 as per the licensee's request.

Issued on this 21 day of August 2017 (A2)

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

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2017;	2017_619550_0004 (A2)	013528-16	Resident Quality Inspection

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA OTTAWA ON K1C 2Z6

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

JOANNE HENRIE (550) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): December 5, 6, 7, 12, 13, 14, 15, 16, 19, 20, 21 and 22, 2016.

This Resident Quality Inspection also included six logs related to critical incidents the home submitted related to allegations of abuse to residents, errors in administration of medication and a fall that resulted in a fracture.

During the course of the inspection, the inspector(s) spoke with the home's Executive Director (E.D.), the Administrator/Clinical Manager, the Director of Care (DOC), the Registered Dietician (RD), the Nutritional Manager, several Dietary Aides (D.A.), the Supervisor for Auxiliary Services, the Coordinator for Auxiliary Services, several Registered Nurses (R.N.), several Registered Practical Nurses (R.P.N.), several Personal Support Workers (PSW), housekeeping staff, the Administrative Coordinator, the Ward Clerk, the Administrative Assistant, the president of the family council, the president of the resident council, several family members and several residents.

In addition, the inspectors reviewed resident health care records, policies related to prevention of abuse and medication administration, family council minutes and resident council minutes. Inspectors also observed resident care and services, staff and resident interaction, and meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Snack Observation

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

19 WN(s)
8 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used,
(a) The resident is assessed and his or her bed system is evaluated in accordance with the evidence-based practices and, if there are none, in accordance with the 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.

On August 21, 2012, a notice was issued to 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" (HC Guidance Document). In the notice, it is written that this HC Guidance Document is expected to be used "as a best practice document". The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the HC Guidance Document are identified as ‘’useful resources’’ and outline prevailing practices related to the use of bed rails.

Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion

documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (U.S., FDA). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including the resident's medical needs, sleep habits and patterns, sleep environment, resident comfort in bed, and potential safety risks posed by using one or more bed rails. The document indicates that if clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs, or a determination has been made that the risk of bed rail use is lower than that of interventions or of not using them, bed rails may be used. The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident medical record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Residence Saint-Louis is a 198 bed home.

On December 6, 2016, Inspector #211 observed that resident #021's mattress was shorter than the deck of the bed frame and there was space between the mattress and the footboard. Inspector #211 informed the Executive Director that RPN #102 confirmed that the resident's bed had potential zone of entrapment (Zone 7) between the end of the mattress and the footboard. On December 6, 2016, Inspector #551 observed spaces between the end of the mattress and the headboard for residents #008, #011, #018 and spaces between the mattress and the footboard for residents #009, #014, #021, #036and #040. Resident #014 informed
Inspector #551 that his/her mattress was sliding and until he/she placed homemade bolsters at the end of the mattress and the footboard.

On December 7, 2016, Inspector #211 observed that the mattress was fitting the deck of the bed frame for resident #021 and there was no space between the mattress and the foot of the bed.

Inspector #211 observed that a plastic pad covered both elevated left half side rails. Inspector #211 was informed by the Coordinator of Auxiliary Services that resident #021's mattress and the bed frame were changed on December 6, 2016.

On December 7, 2016, Inspector #551 provided the list of the residents' names that were found with gaps between the end of the mattress and/or the head or the foot boards on December 6, 2016 to the Administrator/Clinical Manager.

On December 7, 2016, an email sent by the Administrator to the Executive Director and the DOC indicated that the administrator checked the six mattresses identified by inspector #511 as being too short for the residents' bed frame and acknowledged that the following residents' mattresses were too short:
• Resident #008`s mattress has 4 inches gap
• Resident #036`s mattress has 3 inches gap
• Resident #009`s mattress has 4 inches gap
• Resident #014`s mattress has 4 inches gap
• Resident #040`s mattress has 3 inches gap
• Resident #018`s mattress has 3 inches gap
•
On December 13, 2016, the Coordinator of Auxiliary Services provided the Fall 2015 bed audit list completed to Inspector #550. The document indicated that all the bed systems were assessed and given a failing grade, as one or more of the potential zones of entrapment failed the dimensional limit testing; therefore posing risks for entrapment. The audit indicated that the identified beds failed in different identified zones; respectively in zone 1, 2, 3, 4, 5, 6 and 7.

Review of the Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document) identified the different zones for entrapment as followed:
• Zone 1-Entrapment within the rail
• Zone 2-Entrapment under the rail, between the rail support or next to a single rail support
• Zone 3-Entrapment between the rail and the mattress
• Zone 4-Entrapment under the rail, at end of rail
• Zone 5-Entrapment between split bed rails
• Zone 6-Entrapment between the end of the rail and the side edge of the head or foot board
• Zone 7-Entrapment between head or foot board and the mattress end

On December 16, 2016, the Supervisor of Auxiliary Services provided a tracking list (revised on December 16, 2016). The list indicates that the home uses five different types of bed; Hill Rom Electric, Bertec Electric, DMI Electric, MC Healthcare, Arjo Low Bed Electric. It also identified 5 different types of bed rails currently used in the home.

The home's Audit 2015 and the Tracking bed system revised on December 16, 2016 indicated that the zones of entrapment for the following residents were:
• Resident #008's bed failed zone 2, 3, 6, and 7.
• Resident #009's bed failed zone 1 and 7.
• Resident #011's bed failed zone 4, 5, and 7.
• Resident #014's bed failed zone 6 and 7.
• Resident #018's bed failed zone 4 and 7.
• Resident #021's bed failed zone 2, 3, 4, 5, 6, and 7.
• Resident #036's bed failed zone 1 and 7.
• Resident #040's bed failed zone 2, 3, and 6.
•
Interview with the Supervisor of Auxiliary Services on December 14, 2016, acknowledged that steps were not taken to prevent resident entrapment identified on the fall audit 2015.

Interview with the DOC on December 14, 2016, stated that the Coordinator of Auxiliary Services team in the home received bed entrapment training in the fall of 2015 by the Cardinal Health Company. They were told by the Cardinal Health Company that their education was based from the Canadian Entrapment Guideline.

Interview with the Coordinator of Auxiliary Services on December 15, 2016, indicated that all the beds in the home were assessed for entrapment zones by the Supervisor of the Auxiliary Services team. The tool to measure the beds' entrapment was borrowed from the Cardinal Health Company and the tool was sent back to the company after the beds were evaluated. The Audit of bed entrapment was completed in November 2015 and the audit indicated that all beds in the home failed one or more zones of entrapment. The home ordered 108 new mattresses on December 17, 2015, and the mattresses were received from January 19, 2016 to February 3, 2016. The 108 new mattresses were used to replace the old mattresses that the bed had failed the zone entrapment. The home ordered a second lot of 90 new mattresses on December 1, 2016 and the mattresses were received on December 6, 2016. A third lot of seven new

mattresses were ordered on December 12, 2016 and received on December 14, 2016. The Coordinator of Auxiliary Services explained that the bed system was not evaluated after the old mattresses were replaced with the new mattresses to minimize risk of entrapment since the home doesn't have the measurement kit to assess entrapment.

Interview with the Coordinator of Auxiliary Services on December 15, 2016, stated that the licensee used one identified bed frame as a model and one of the new mattress received in 2016 to assess and to ensure that the zone 2 as identified as one of the most potential area for entrapment was resolved. The Coordinator of Auxiliary Services acknowledged that the above model was not sufficient to assess the risk of entrapment zones since the home has different types of bed frames and the mattresses received from January 2016 to December 14, 2016 were with different length.

On December 14, 2016, review of the health care record for the following residents indicated:
Resident #008 was admitted with several medical health issues. The resident`s current plan of care did not indicate that the resident was using side rails. The resident`s MDS quarterly review assessment on a specific date indicated that the resident is not using the full or the other types of side rails. On December 15, 2016, resident #008 had the left full side rail elevated and the resident was not in bed. Interviews with PSW #123 and RPN #122 on December 15, 2016, indicated resident #008 was able to get out of the bed independently and the left full side rail placed beside the resident`s bedroom wall was to prevent the resident from falling between the bed and the wall.

Resident #009 was admitted with several medical health issues. The resident`s current plan of care did not indicate that the resident was using side rails. The resident`s MDS quarterly review assessment on a specific date in 2016, indicated that the resident is not using the full or other types of side rails. On December 15, resident #009 has the left full side rail elevated while the resident was lying in bed. Interview with resident #009 on December 16, 2016, indicated that he/she requested to have the left full side rail elevated for safety. Interview with PSW #119 on December 16,
2016, stated that resident #009`s left full side rail was elevated but usually the resident`s side rail is not elevated. Interview with RN #124 on December 16, 2016, stated resident #009`s left full side rail was elevated for safety and to prevent a fall. RN #124 indicated that the left full side rail should have been identified in the

resident`s current plan of care.

Resident #011 was admitted in the home in 2016 with several medical health issues. The resident`s current plan of care indicated that the resident is using the two half side rails to assist with repositioning. The resident`s MDS on a specific date in 2016, indicated that the resident is using the full bed side rails every day. On December 16, 2016, resident #011 has both upper quarter side rails elevated in the resident`s bed. The resident was not in bed. Interview with PSW #119 on December 16, 2016, stated resident #011`s two upper quarter side rails are elevated during the night and when the resident was lying in bed. Interview with RN #124 on December 16, 2016, stated that the resident #011 used both quarter side rails for repositioning when he/she is in bed.

Resident #014 was admitted with several medical health issues. The resident`s current plan of care did not indicate that the resident was using side rails. The resident`s MDS quarterly review assessment on a specific date in 2016, indicated that the resident is not using the full or other types of side rails. On December 16, 2016, resident #014 has the right full bed side rail elevated while in bed. Interview with resident #014 on December
15, 2016 indicated that he/she needs the right full bed side rail elevated when in bed. Interviews with PSW #119 and RN #124 on December 16, 2016, stated that the right full bed side rail is elevated as requested by resident #014 for personal reasons.

Resident #018 was admitted in the home in 2010 with several medical health issues. The resident`s current plan of care indicated that the resident needs to be turned and repositioned every two hours due to a decrease in mobility. The resident`s current plan of care did not indicate that the resident was using side rails. The resident`s MDS quarterly review assessment on a specific date in 2016, indicated that the resident is using the full bed side rails every day. On December 15, 2016, resident #018 had the left quarter side rail elevated beside the bedroom wall without the resident being in bed. Interview with PSW #130 on December 15, 2016, indicated resident #018 was using the left quarter side rail placed beside the resident bedroom wall when he/she was in bed for repositioning.

Resident #021 was admitted with several medical health issues. The resident`s current plan of care did not indicate that the resident was using side rails. The resident`s MDS quarterly review assessment on a specific date in 2016, indicated that the resident was not using the full or other types of side rails. On December

15, 2016, resident #021 has the two left quarter side rails elevated covered with a plastic bumper. Interviews with
PSW #131 and RPN #105 on December 16, 2016, stated that resident #021`s four quarter side rails on each side of the resident`s bed were elevated during the night to prevent the resident from falling. PSW #131 indicated that the left two quarter side rails were put down after she had transferred the resident from the bed to the wheelchair. The bumper cover on the two left quarter side rails was to prevent the resident from hitting his/her legs on the left side rails.

Resident #036 was admitted with several medical health issues. The resident`s current plan of care did not indicate that the resident was using side rails. The resident`s MDS annual assessment on a specific date in 2016, indicated that the resident is not using the full or other types of side rails. On December 15, 2016, resident #036 had the left half quarter rail elevated without the resident being in bed. Interviews with PSW #123 and RPN #122 on December 15, 2016, stated resident #036 was able to get out of her bed independently and the left quarter side rail was elevated
beside the resident`s wall to prevent the resident from falling between the bed and the wall.

Resident #040 was admitted with the diagnosis of dementia and other health issues. The resident`s current plan of care indicated that the resident is using her bed rails and staff need to cue resident for repositioning. The resident`s MDS quarterly assessment on November 22, 2016, indicated that the resident is not using the full or other types of side rails. On December 15, 2016, resident #040 had the left full side rail elevated beside the resident`s bedroom wall while the resident was in bed. Interview with PSW #125 on December 15, 2016, stated that resident #040 was using both full side rails when in bed to prevent a fall.

Observation and review of the above residents' health care record, their current plan of care and their most recent quarterly assessment (MDS) indicated that there was conflicting information relating to the use of side rails.

Review of the Supervisor of Auxiliary Services list on December 19, 2016, indicated the beds and/or the mattresses were changed on the following dates:
• Residents #008, #009, #036, and #040's mattress was replaced between December 7, 8, 9, 2016
• Resident #011's mattress was replaced on December 15, 2016
• Resident #014's bed frame and a 84 inches mattress was replaced on December

14, 2016
• Resident #018's 84 inches mattress was replaced on December 15, 2016
• Resident #021's mattress was replaced on December 6, 2016 and the bed frame was replaced on December 7, 2016 because the mattress was too short.

On December 14, 2016, the Administrator/Clinical Manager and the Supervisor of Auxiliary Services on December 14, 2016, revealed after changes were made to the above identified bed systems, steps were not taken to assess the new bed system. The bed system was not evaluated because the home does not have the measurement kit to assess the potential zone of entrapment. The Executive Director indicated that the home was presently in the process of ordering the measurement kit to assess all the beds in the home.

Over the course of the inspection and interview with the Coordinator of Auxiliary Services on December 15, 2016, it was identified that after the Audit in 2015, when changes were made to a resident's bed systems such as a change of mattress or bed rails from January 2016 to December 14, 2016, the home did not have a process in place to ensure that the resulting new bed system was evaluated in accordance with evidence based practices since the home did not have the entrapment assessment tool to minimize risk to the resident.

Interview with the Supervisor of Auxiliary Services on December 19, 2016, confirmed that the tracking list system reviewed on December 16, 2016, does not identify the date when the old mattress was exchanged for a new mattress for each beds during the period from January to December 2016, excluding the recent beds from December 7 to December 15, 2016. The tracking system does not identify the dates of side rails modifications. The process does not keep a track of residents internal transfers and if the bed systems were changed.

On December 19, 2016, the DOC and the Executive Director acknowledge that the licensee doesn't have the following practice:
• to evaluate resident's bed system where bed rails are used to minimize risk to the resident,
• education for staff to evaluate resident's bed system where bed rails are used to minimize risk to the resident, and
• information packages for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, whether beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or

myths associated with bed systems and the use of bed rails.
•
The severity of harm related to resident's bed assessment and risk of potential zone of entrapment was determined to be "potential for actual harm". The scope was identified as "widespread" as the residents using bed rails were not assessed, neither was the bed systems evaluated and steps were not taken into consideration to prevent resident entrapment. [s. 15. (1)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

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

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated

and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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.

Resident #019 has resided at the home since 2009. The resident is alert and oriented and has specific medical health issues.

On December 5, 2016, two half bed rails were noted to be in a raised position. On subsequent observations, it was noted that the resident's bed had four split rails,

which when raised form a full rail on each side of the bed. The resident stated that these four split bed rails have been in place since her admission and have not changed. With regards to the bed rails, resident #019 stated that he/she did not have a choice, "the bed is there, so are the rails". The resident stated that he/she wanted them for security, and that the staff often forgot to raise one split rail at the bottom of the bed which he/she reminded them to do.

According to the documentation in Point of Care for the month of December 2016, the resident requires limited assistance to extensive assistance to total dependence for bed mobility.

According to the written plan of care, the resident uses two upper half rails for positioning.

RPN #105 stated that residents with raised bed rails are monitored but the monitoring is not documented anywhere.

The written plan of care does not set out clear directions with regards to the use of four split rails on resident #019's bed. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Resident #049 has several diagnoses. A review of the resident health care record noted a gradual weight loss for an identified period of six months in 2016. It was identified that the resident lost 6.8 kgs in that identified period of time.

Inspector #148 observed the resident at three meal services. At the December 5, 2016, lunch service the resident was observed with the soup course and not feeding self. The resident appeared distracted and tapped the table and his/her lap. At a point in the service the soup was removed whereby the resident did not consume any of the soup. At 1240 hours the resident was served the main plate, again the resident was observed to be distracted and did not make an attempt to feed self. At 1245 hours a PSW approached the resident and provided verbal encouragement, when this was unsuccessful the same staff person then provided physical feeding assistance. The resident accepted this assistance and ate more than 75% of the meal.

At the December 13, 2016, breakfast meal service, at approximately 0855 hours, resident #049 was seated at a table where both cereal and plated meal were held. The resident was provided verbal encouragement twice between 0855 and 0907 hours, however did not consume any of the cereal or meal. At 0908 hours and again at approximately 0912 hours the RN on the floor approached and provided physical assist to the resident whereby the resident took well. No further physical assist was provided and at 0915 hours the cereal was removed. The resident was provided verbal encouragement twice between 0915 and 0921 hours, with no further physical assist. The resident consumed only half of toast served.

The plan of care indicates that resident #049 requires encouragement but no physical assist. The plan of care is not based on the needs of the resident, whereby the resident was observed to require physical assist and/or encouragement alone was not sufficient to assist with feeding. [s. 6. (2)]

3. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Resident #011 has a history of falls, most of which occurred in the resident's bathroom or at the side of the bed. In review of the health care record and in speaking with RN #103, many falls were related to the resident's need for toileting and the resident attempting to transfer self. The most recent MDS assessment, completed on a specific date in 2016, describes resident #011 as incontinent of urine and bowel, with the need to use incontinent products. The assessment also indicates that the resident requires total assistance by one staff member for toileting.

During an interview with the regular PSW #119, who was responsible for care on December 20, 2016, it was reported that the resident is toileted with assistance on the day shift every two hours. PSW #119 also described that the resident uses briefs due to incontinence.

The plan of care for resident #011, reviewed the morning of December 20, 2016, did not include the resident's need for regular toileting, the level of assistance required, nor did the plan outline the need or preferences of the resident's use of incontinence products. It was noted that after the Inspector spoke with RN #103, toileting and level of assistance was added to the plan, which included the need for two staff to assist. However, the plan did not include the toileting plan or preference for incontinence products.

(Log 015156-16) [s. 6. (2)]

4. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM was provided with the opportunity to participate fully in the development and implementation of the plan of care.

During an interview on December 06, 2016 by Inspector #211 and again on December 15, 2016 by Inspector #550, resident #006 indicated he/she cannot eat certain foods because of problems swallowing due to a specific diagnosis. The resident indicated he/she is supposed to have liquids with meals as per a doctor's recommendation to help swallow but he/she is not getting them.

Inspector #550 reviewed the resident's health care records. The resident was admitted to the home in 2014. The admission MDS assessment completed by the placement coordinator, dated a specific date in 2014, indicated an issue with swallow and a current medical diagnosis of esophagitis. The inspector reviewed the resident's latest MDS assessment dated a specific date in 2016 and noted that it indicated the resident had no swallowing problems. The resident's current plan of care indicated that the resident is on a regular texture diet with no added salt. The plan of care did not indicate any concerns with the resident's swallowing nor interventions to address any swallowing issues.

During an interview on December 15 and 20, 2016, the Dietitian indicated to the inspector she was not aware that resident #006 had any swallowing problems. She indicated that when she completes an assessment for a resident, she does not always speak to the resident especially if she knows the resident; she will rely on the documentation in the progress notes and in point of care. She further added she spoke to the resident after speaking to the inspector on December 16th and added specific interventions to the resident's plan of care to help with swallowing.

As evidenced above, resident #006 was not provided with the opportunity to participate fully in the development and implementation of her plan of care. [s. 6. (5)]

5. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #032 was diagnosed with specific diagnoses. A review of the resident's weight history indicated that since September 2016 there has been a gradual

weight loss; it was noted that the resident lost 9 kgs in three months.

In review of the resident's health care record the resident was ordered a nutritional supplement, as needed when the resident refuses meals or consumes less than 50%, this was confirmed by both the most recent MDS assessment and electronic plan of care. Inspector #148, in the company of the home's RD, reviewed the resident's recent food and fluid intake records and noted several instances of refusal and less than 50% consumed. The Inspector also observed the resident during the lunch meal service of December 5 and 13, 2016 and noted that the resident refused the main meal.

A review of the Medication Administration Records, whereby the administration of the nutritional supplement is recorded, it was demonstrated that between a specific period of time in December 2016, the nutritional supplement was administered once.

The plan of care as it relates to the administration of a nutritional supplement was not provided to resident #032 as set out by the plan of care.

Inspector #148 observed resident #049 at the lunch meal service on December 13, 2016. A review of the resident's health care record notes a gradual weight loss for six specific months in 2016. The resident's plan of care, under the heading of "Eating" indicates that the resident requires encouragement to consume 100% of the meal.
The resident was served soup at 1229 hours and began to consume soup well on his/her own, then after a time became distracted and ceased attempts to feed self. At 1240 hours a staff member served the main meal and removed the soup bowl with less than 50% taken. During the soup course, no staff approached the resident to provide encouragement. After the main meal was served the resident began to eat on his/her own, after a few minutes the resident became distracted and ceased attempts to feed self. At 1250 hours the Inspector noted that the resident had not made further attempts to feed self and no staff had approached to provide encouragement. At 1253 hours the resident began to eat on his/her own; at 1306 hours the resident's plate was removed and dessert was served with approximately 50% of the main meal consumed.
Over this meal service, resident #49 was observed not to be provided encouragement, as set out by the plan of care.

Resident #046 has a specific diagnosis. Inspector #148 observed the resident

during the breakfast meal service on December 13, 2016. Resident #046 was observed at 0844 hours with plate of toast, bacon and eggs, alongside a small container of mandarin oranges. The resident was observed to move the spoon around the outside of the container of mandarins with no attempt to feed self. The resident then poured the oranges out on the placemat, dumping all of the oranges and then proceeded to spoon the liquid on the placemat to the toast on the plate. At the same time, a co-resident seated at the table was observed to pull resident #46's plate and consume the entirety of the resident's bacon. At 0845 hours, having observed the co-resident eating resident #046's food, the dietary aid pulled the plate away from the co-resident. At 0849 hours RPN #105, approached the residents table to pick up the spilled oranges and then threw them in the garbage. During the next few minutes, the co-resident was observed to consume approximately 50% of the toast from the resident's plate, while resident #046 was consuming toast and bites of egg. When the RPN observed this, she proceeds to pull the co-resident away from the table. At 0857 hours the plate was removed by the RPN; the resident had not consumed any of the mandarin oranges or bacon and had consumed only bites of toast and egg, due to the co-residents consumption of resident #046's food and the inability of resident #046 to feed self. Upon discussion with RPN #105, in the presence of RN #117, the RPN reported that the resident ate about 25% of the meal and noted that when she doesn't eat a good breakfast she will eat a good lunch. Inspector #148 was present for the lunch meal service on December 13, 2016 and noted that resident #046 consumed less than 25% of the main meal.

The plan of care for resident #046 indicates that the resident requires set up assistance and one staff to provide hands on support to eat when more fatigued. Resident #046 was observed to be approached by the RPN when having difficulty feeding self, however, no action was taken to ensure assistance with feeding was provided nor was action taken to replace food items that were either lost due to the resident's attempts to feed self or the food consumed by co-resident. [s. 6. (7)]

6. Resident #054 was admitted to the home in 2015 with multiple diagnosis. The resident has a known history of a specific behaviour towards residents in the home when he/she is not being supervised.

On a specified date in 2016, the sitter who was to assume one on one duty with resident #054 for the day shift arrived at 0720 hours. Upon her arrival, RN #103 who was assuming one on one supervision with the resident until the sitter's arrival left and informed the staff that she was now leaving. RPN #114 took the sitter

aside to the report room which is located diagonally across the hall from resident #054's room to give her a short report since this sitter had never worked with resident #054 before. By the time she started giving the sitter her report, they heard resident #057 yelling from the dining room. When staff arrived in the dining room, they found resident #054 in front of resident #057 and #011's table naked, asking the residents if they wanted to kiss him/her.

A review of the resident's plan of care indicated:
-Constant supervision - resident has 1 on 1 on days, evenings and nights. When going on break, advise co-worker and ensure resident is in his room and monitored. Ensure reason for 1 on 1 is communicated to all staff every shift.
-Ensure resident is not placed beside specified residents in unsupervised areas. When at mass or in Dining room ensure supervision.

A note in the communication binder for the resident dated November 2, 2016 titled "Important directions for PSW's working with resident #54" indicated:
-close supervision at all time - do not leave alone without having someone else watch him/her
-please discuss your break time with the registered staff so they can make sure it is a good time for you to go to ensure the resident will be watched in your absence.

During an interview, RPN #114 indicated to the inspector that she took the sitter aside to the report room to give her report and that the resident had been left alone in his/her room. She further indicated being aware that the resident requires constant supervision but this was not followed when she took the sitter aside. [s. 6. (7)]

7. The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

During a family interview, resident #021's family member indicated to the inspector that the resident was not getting two baths per week.

Review of the current written plan of care indicated that resident #021's bath was scheduled on Monday and Thursday mornings.

The resident's health care record in point click care (PCC) revealed the bathing was not documented on November 17, 24, 2016 and on December 1, 2016.

Interview with PSW #129 on December 16, 2016, acknowledged that the resident's bath was not documented in the resident's health care record for a specific date in December 2016. PSW #129 stated that the residents schedule baths are given and if a resident refused his/her bath, she will document the refusal. PSW #129 did not document that the resident received his/her bath.

Interview with RPN #105 on December 16, 2016, revealed that resident #021 received his/her bath as scheduled on the resident's health care record because at the end of each shift she will verify with the staff that the residents' bath has been received as scheduled. RPN #105 stated that resident #021 never refused having his/her bath.

Interview with PSW #132 on December 19, 2016, revealed that resident #021 received his/her bath as scheduled on a specific date in November 2016, but has not documented it.

Interview with PSW #133 on December 19, 2016, revealed that resident #021 received his/her bath as scheduled on a specific date in November 2016, but has not documented it.

Interview with the DOC acknowledged that resident #021s' bathing was not documented on three specific dates in November 2016 and a specific date in December 2016 under the section "Documentation Survey Report" in the resident's health care record.

The licensee has failed to ensure that the provision of the care set out in the plan of care related resident #021's scheduled bathing was documented. [s. 6. (9) 1.]

8. On December 6 and 16, 2016, resident #009 was observed having long facial hair. As per RPN #121 shaving of resident #009 is done on bath days. Inspector reviewed the documentation for bathing in POC for resident #009 to determine the last bath day. Upon a review of the documentation for November and December 2016, the inspector noted that there was documentation for 1 out of 8 possible baths in November and 0 out of 5 possible baths for December.

The inspector then reviewed the documentation regarding bathing for resident #011 and noted that in November there was documentation for 2 out of 9 possible baths and in December there was documentation for 2 out of 4 possible baths.

During an interview on December 16, 2016, PSW #119 indicated documentation of baths is done in POC. PSW #119 told the inspector that although she gave resident #009 his/her bath yesterday, she did not document this in POC because the resident was not assigned to her. The Administrator/Clinical Manager indicated to Inspector #550 that bathing for all residents is to be documented in POC and it should be documented by the PSW who provided the care to the resident.

As evidenced above, the provision of the care set out in the plan for residents #009 and #011 was not documented. [s. 6. (9) 1.]

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

On December 13, 2016, Inspector #211 observed resident #024 receiving a specific therapy.

Resident #024 was admitted in the home in 2014 and diagnosed with a specific disease and other medical health issues.

Health record review dated a specific date in 2016, indicated that resident #024 was diagnosed with a specific acute medical condition. The physician prescribed a specific test and a specific medication to be administered for a specific period of time.

Resident #024 was sent to the hospital ten days later and returned to the home four days later. The day of the resident's return from hospital, the health record indicated that the physician spoke with the family to change resident's level of care.

The re-admission order form indicated to administer a specific therapy to maintain specific levels in the resident's blood.

The specific therapy was not re-ordered in the Physician's Order Review upon the resident's return from hospital.

Interview with the PSW #104 on December 13, 2016, indicated that she was told one month ago to administer a specific therapy to the resident with specific guidelines.

Interview with RN #103 on December 13, 2016, indicated that resident #024 is presently receiving a specific therapy with specific guidelines. The therapy can be calibrated at a specific rate range as needed. RN #103 stated that the current plan of care indicated that the resident is receiving the specific therapy but does not give clear direction to the staff related to the calibration permitted for resident #024. RN #103 stated that the administration of the therapy was not recorded in the resident's Medication Administration Record for two specific months in 2016. RN #103 indicated that the therapy for resident #024 was not re-ordered on the quarterly physician's order review on a specific date and therefore the resident's medication administration records (MAR) for two specific months has no order for the specific therapy.

Review of the home's policy regarding the administration of the specific therapy indicated that the administration of this therapy is to be performed by the Registered Nurse and the Registered Practical Nurse. The administration of the therapy requires a physician order with specific directives.

Interview with the DOC acknowledged that a resident receiving a specific therapy needs a physician order and the resident's MAR must identified the type of therapy with specific directives.

Interview with the Administrator confirmed that the registered nurse (RN & RPN) staff should have obtained a physician's order for the specific therapy.

The licensee has failed to ensure that the resident who was receiving a specific therapy was reassessed and the plan of care reviewed and revised when the resident's care needs was changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care for resident #011 is revised to include the toileting plan and preference for incontinence products for this resident and to ensure that the care set out in the plan of care is provided to resident #054 as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Related to log #027667-16.

A CIS report was submitted to the Director reporting an incident of resident to resident sexual abuse. It was reported that on a specific date in 2016, resident #054 was left unattended for a couple of minutes and went into the dining room on unit 3AB naked and was asking two residents if they wanted to kiss him.

Inspector #550 reviewed the CIS report and noted that the incident of sexual abuse was not immediately reported to the Director. The inspector reviewed the health care records of resident #054, #011 and #057 and was unable to find any documentation in resident #011 and #057's progress notes regarding the incident.

During an interview on December 21, 2016, the Administrator/Clinical Manager indicated that RN #103 should have immediately communicated the incident of sexual abuse to her via telephone and not via email like she did. RPN #114 should have documented the incident in resident #011 and #057's progress notes.

The inspector reviewed the home's abuse policy titled ''Abuse and Neglect, Long-Term Care'', policy #CLIN CARE 32 LTC, revised 2016-11. On page 2 of 4, 4.0 Reporting procedures indicated:
4.2 The supervisory staff or nurse immediately notifies the administrator, director of care or delegate by phone, pager or in person. Do not leave a voice message or send an email; if the administrator or director of care cannot be reached immediately, contact their delegate. The administrator, director of care or delegate immediately notifies the executive director of Long-Term Care.

Page 3 of 4, 7.0 Documentation in the health record indicated:

7.1 The clinical staff who witness an event or who it is reported to document the nature of the incident, the time it occurred, resident status, name of persons notified, interventions, follow-up actions, and resident response in the progress notes, omitting any opinions conclusions, accusations, or other statements assigning fault or blame to others.

As evidenced above, RN #103 who was the nurse responsible for that unit on a specified date in 2016, did not comply with the home's policy on abuse regarding reporting procedures and RPN #114 who the incident of sexual abuse was reported to, did not comply with the home's policy regarding the documentation in health care records. [s. 20. (1)]

2. Related to Log #034895-16

The Ministry of Health and Long-Term Care (MOHLTC) after-hours pager was contacted on a specific date in 2016 to report an allegation of staff to resident abuse, under LTCHA, 2007, s. 24, and a Critical Incident Report (CIS) was submitted the following day.

According to the CIS report, on the evening shift of a specified date in 2016, PSW #139 is reported to have hit resident #058 on the back of the head, and the resident said that he/she had been mistreated. The resident reported the incident on the same day to staff on the night shift.

A review of the resident's health care records revealed that at a specified time on a specific date in 2016, RN #140 wrote a progress note stating that the resident had reported being hit on the back of the head by a PSW, and that he/she did not want this PSW providing his/her care.

On December 22, 2016, the Administrator was interviewed and stated that she was informed of the incident on a specific date in 2016, in the morning after returning from an off-site meeting, through a voice mail message left by RN #140 on the previous night shift.

According to the Administrator when RN #140 became aware of the allegation of staff to resident abuse, she should have contacted the nursing supervisor at St Vincent's who would have reported the allegation to the Director or contacted the clinical on-call manager.

The home's policy titled Abuse and Neglect, Long-Term Care (CLIN CARE 32 LTC) states that during off hours, the clinical nursing supervisor or the clinical on-call if the supervisor is not available is to be immediately notified.

The Director was not immediately notified of an allegation of staff to resident abuse

that occurred on a specified date in 2016 on the evening shift; the Director was not notified until the following day at a specified time in the evening. s. 20. (1)]

3. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall:
(d) contain an explanation of the duty under section 24 of the Act to make mandatory reports
(f) set out the consequences for those who abuse or neglect residents

Related to log #027667-16.

Following the report of an incident of resident to resident sexual abuse that occurred on a specific date in 2016, Inspector #551 requested the home's abuse policy. The Administrator/Clinical Manager provided the inspector with a policy titled ''Abuse and neglect, Long-Term Care'', policy #CLIN CARE 32 LTC, with a revision date of 2016-11 which she identified as their current abuse policy.

Upon reviewing the policy, the inspector noted that it did not contain an explanation of the duty to protect under section 24 to make mandatory reports and it did not set out the consequences for those who abuse and neglect residents.

During an interview, the Administrator/Clinical Manager confirmed that these two provisions were missing from their policy. She further indicated the policy was recently revised to be specific to the LTC sector and that these provisions may have been taken out from the old policy by mistake. [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's abuse policy is revised to include all the provisions in the LTCHA and that it is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Related to log #027667-16.

A CIS report was submitted to the Director by the Licensee on a specified date in 2016 reporting an incident of resident to resident sexual abuse that occurred on a specified date in 2016.

On a specified date in 2016, resident #054 who is known to have a sexually inappropriate behaviours towards female residents and who is to have one on one supervision at all times, was left unattended for a few minutes. RPN #114 had taken the resident's sitter aside to the report room which is located diagonally across the hall from resident #054's room to give her a short report since this sitter had never worked with resident #054 before. By the time she started giving the sitter her report, they heard resident #057 yelling from the dining room. When staff arrived in the dining room, they found resident #054 in front of resident #057 and #011's table naked, asking the residents for kisses.

During an interview on December 20th, 2016, RPN #114 indicated to the inspector she immediately informed RN #103 of the incident of sexual abuse by telephone. RN #103 indicated to the inspector she immediately informed the Administrator/Clinical Manager of the incident via email at 0750 hours.

The Administrator/Clinical Manager indicated to Inspector #551 that she was made aware of the incident via an email she received from RN#103 early morning on the day the incident occurred which she read sometime that morning. She indicated she did not immediately report this incident to the Director as she was not sure that it was considered as sexual abuse. The following day she decided to report the incident to the Director as resident #057's daughter was upset and after much thinking about the incident she had decided it would possibly be considered as sexual abuse. After reviewing the definition of sexual abuse in the home's abuse policy, and the ''Licensee reporting of sexual abuse'' decision tree with the inspector, the Administrator/Clinical Manager confirmed that the incident was an incident of sexual abuse and that she should have reported it immediately to the Director. [s. 24. (1)]

2. Related to Log #034895-16.

The Ministry of Health and Long-Term Care (MOHLTC) after-hours pager was contacted on a specific date to report an allegation of staff to resident abuse, and a Critical Incident Report (CIS) was submitted on the following day.

According to the CIS report, on the evening shift of a specified day in 2016, PSW

#139 is reported to have hit resident #058 on the back of the head, and the resident said that he/she had been mistreated. The resident reported the incident on the same day to staff on the night shift.

A review of the resident's health care records revealed that on a specified date in 2016, RN #140 wrote a progress note stating that the resident had reported being hit on the back of the head by a PSW, and that he/she did not want this PSW providing his/her care.

On December 22, 2016, the Administrator was interviewed and stated that she was informed of the incident the following morning after returning from an off-site meeting, through a voice mail message left by RN #140 on the previous night shift. She further indicated she waited to speak to PSW #139 who was scheduled to work at 1500 hours before notifying the Director of the incident of alleged abuse.

The licensee was informed of an alleged incident of staff to resident abuse on the morning of a specified date in 2016. This incident was not immediately reported to the Director; it was reported in the evening on a specified date in 2016. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is immediately informed of any 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a seat belt and bed rail restraints were included in the resident's plan of care.

Resident #021 has resided at the home since 2003 and is cognitively impaired.

On December 6, 2016, a bed rail was observed to be in a raised position while the resident was not in bed by inspector #211.

On December 15, 2015, resident #021's bed system was observed and four split rails, which when raised form a full rail on each side of the bed, were observed.

On December 15, 2015, resident #021 was observed sitting in a wheel chair with a front closing seat belt applied. When the resident was asked what this was, referencing the seat belt, the resident did not acknowledge it, and was unable to physically or cognitively release it.

On December 16, 2016, PSW #131 stated that when resident #021 was in bed, the four rails were raised because he/she moved while in bed and would fall if the rails were not raised. On the same day, RPN #105 stated that the resident wore a front closing seat belt to keep him,/her in the chair as without it, he/she would try to get up and fall.

The resident's health care record was reviewed. According to the most recent Minimum Data Set (MDS) assessment, the resident was identified as not using a trunk restraint or a chair that prevents rising, and the resident did not use any bedrails.

The current written plan of care was reviewed, and there was no indication that the resident wears a front closing seat belt or that any bed rails are used when the resident is in bed.

Additionally, it was noted that a physician or nurse in the extended class had not ordered the restraining with a front closing seat belt and bed rails, and the restraining of the resident had not been consented to by the resident's SDM.

The home's policy titled "Restraint Minimization" was provided by the Administrator and stated that:
-a Physician's Order for Physical Restraints is required to order a restraint
-all restraints used must follow a plan of care that the patient of substitute decision maker has given
consent to, except in emergency situations

On December 15, 2016, the DOC stated that the use of restraints should be included in the resident's plan of care. [s. 31. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the seat belt and bed rails are included in resident #021's plan of care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written approaches to care are developed to meet the needs of the residents with responsive behaviours that include:
• screening protocols
• assessment
• reassessment, and
• identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

Resident #043 was admitted to the home in 2016 with multiple diagnoses.

A review of the resident's health care records indicated that the resident is physically aggressive towards staff during care. MDS assessment on a specified date in 2016 indicated in section E4CA that the resident exhibits physically abusive behavioural symptoms on a daily basis.

On December 13, 2016, during an interview, RPN #108 and PSW #107 indicated to Inspector #550 that resident #043 is physically aggressive towards staff during care, he/she often refuses care and that this behaviour occurs almost on a daily basis. After care is completed, the resident is in a good mood and no longer aggressive.

Inspector reviewed the resident’s actual written plan of care and was unable to find any documentation indicating that resident #043 had any responsive behaviour and that triggers were identified.

RN #109 and RPN #108 indicated to the inspector that the resident’s behaviour and identified triggers were not documented in his/her plan of care. [s. 53. (1) 1.]

2. The licensee has failed to ensure that the written strategies include techniques and interventions to prevent, minimize or respond to the responsive behaviours.

As per resident #043's health care records and interviews with staff, the resident was identified as being physically aggressive towards staff during care.

During an interview on December 13, 201, RPN #108 and PSW #107 indicated to the inspector that the resident is physically aggressive towards staff during care and often refusing care. They indicated that the approach staff use when they provide care to this resident is very important; they need to speak in a gentle way and be calm so they will not provoke the resident. Care has to be provided by two staffs when the resident is physically aggressive.

Reviewed the actual plan of care for the resident with RPN #108 and observed that the interventions to mitigate the aggressive behaviour were not identified in the resident's plan of care.

RN #109 indicated to the inspector that written strategies to address resident's responsive behaviours do not include techniques and interventions to prevent, minimize or respond to the responsive behaviours for resident #043 as identified by RPN #108 and PSW #107. [s. 53. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #043's plan of care is reviewed to include the identification of behavioural triggers that may result in responsive behaviours and written strategies include techniques and interventions to prevent, minimize or respond to the responsive behaviours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

During the resident interviews conducted for Stage 1 of this inspection, five resident reported concern with the provision of a between-meal beverage, one specific to the morning pass and four of these residents reside on the third floor.

On December 15, 2016, Inspector #148 observed the 3A unit between 1000 hours and 1120 hours. The Inspector was in view of two hallways, where residents were noted to be in their rooms and the small dining space where resident #051 and #052 were seated. Over the course of the observation no between-beverage was offered to the hallways and/or residents in view. At 1120 hours resident began to assemble in the dining rooms for lunch.

The Inspector spoke with residents #005, #024 and #035, who reside on the AB unit. All three residents indicated that they did not receive a beverage pass between breakfast and lunch.

On December 13, 2016, Inspector #148 observed the 2C unit for a period of time. After observing the breakfast service which continued to at least 0950 hours, the Inspector continued to observe the unit 1115 hours. At no time was a between-meal beverage offered to residents on this unit. [s. 71. (3) (b)]

2. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

Inspector #148 observed three meal services on the 2C unit. The unit was confirmed to have five residents requiring thickened nectar fluids. During all three observations it was noted that residents requiring thickened fluids were not offered tea, coffee or milk.

During the breakfast meal service on unit 2C, PSW #110 reported to the Inspector, that she could not give tea or coffee to those needing nectar fluids. She further noted that there was a milk product in the fridge and that residents could ask for this.

The Inspector reviewed the planned menu which includes water, juice, tea, coffee and milk.

On December 14, 2016, the Inspector spoke with the home's Registered Dietitian, who approved the current menu and agreed that it was the expectation that those residents requiring thickened beverages be offered tea, coffee and milk.

In addition, it was observed at the December 5, 2016, observation of the lunch meal service that bread was not offered as described by the planned menu. The Inspector brought this to the Dietary Aide's attention at the end of service, at which time the Dietary Aide proceeded to serve resident's the puree bread who had already been served their meal.

On December 5, 2016, during the Inspector's observation of the lunch meal service on unit 2C, resident #032 was observed not to consume the main meal after having fed him/herself the soup. At 1250 hours, a staff member approached the resident to ask if he/she wanted a sandwich instead. The resident was agreeable and a

sandwich from the servery fridge was provided. The planned menu alternative was not available to the resident as the hot food cart had been removed from the unit at 1240 hours. Similarly, during observations of December 13, 2016, resident #032, again, did not consume the main meal after having consumed the soup. When approached by staff to offer alternatives the planned alternative was no longer available to be offered to the resident as the hot food items had been removed from the unit. In both cases the resident's plate was removed with minimal consumed.

On December 5, 2016, during the observed lunch meal service on unit 1C and 2C it was noted that the planned alternative entrée of beef was not available for the puree and minced therapeutic. Inspector #148 spoke with the NM, who reported there was a production issue on December 4, 2016 that had led to this error and she was aware [s. 71. (4)]

3. The licensee has failed to ensure that the planned menu items were offered and available at lunch on December 5, 2016.

Resident #042 was admitted to the home in 2016. According to the physician's orders, the resident is ordered a general diet, regular texture, and regular consistency liquids.

On December 5, 2016, the lunch meal was observed on unit 1 C, and the following was noted:

At 1232 hours, resident #042 was escorted to the dining room and served soup.

At 1249 hours, the resident had soup at her place setting, and the dietary aide had left the unit with the food cart.

At 1303 hours, the dessert cart was removed from the unit, and at 1317 hours, the doors to the servery were locked.

At 1319 hours, the soup bowl was cleared from resident #042. The resident had consumed ¾ of a glass of water and some soup. The resident was not offered an additional serving of soup. After the soup was removed, resident #042 was not offered or provided an entrée or dessert.

RPN #122 stated that Resident #042 did not each much and took a nutritional

supplement, milk and soup only on most days.

Resident #042's current weight is 33.6kg, BMI 15.6. He/she has lost 4% body weight in one month, 7.4% in three months, 18.6% in six months and 29.4% since admission.

The resident's plan of care was reviewed. Under the focus "diet orders" with a goal of "nutritional needs to be met", the interventions include offering the resident a specific nutritional supplement to promote weight gain and to provide small portions to avoid overwhelming the resident. There was no indication that the resident was not to be offered an entrée and dessert. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner and to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that that the home has a dining and snack service that includes, at a minimum, course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

On December 13, 2016, Inspector #148 observed the breakfast meal service on unit 2C. As described elsewhere in this report, several items of hot food were pre-plated for four identified residents. In all instances, food was not served course by course. As exampled by both resident #049 and #050 who had both their dry cereal and hot food served at the same time.

On December 13, 2016, Inspector #148 observed the lunch meal service on unit 2C. Resident #045 was observed over the duration of the service. At 1238 hours a staff member was observed to serve the resident with the main course prior to the resident having finished consuming the soup course. The resident did not begin to eat the main plate until 1245 hours. While consuming the main course, staff served the resident the dessert. At the same meal service resident #046 was served the main meal at 1240 hours while the resident was still consuming the soup course. Resident #021 was also observed at this meal service to be served both the soup course and main course at the same time.

The health care records of the residents noted above did not indicate any

contradiction to course by course service and in some cases course by course service was provided to the resident identified during subsequent meal observations. [s. 73. (1) 8.]

2. The licensee has failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

On December 13, 2016, Inspector #148 entered the dining room on unit 2C at 0800 hours and noted resident #047 to be seated with puree prunes. The resident was provided feeding assistance at 0842 hours.

On December 13, 2016, Inspector #148 observed resident #021 to be served soup and meal at 1254 hours during the lunch meal service on unit 2C. Assistance was not provided to the resident until 1300 hours. [s. 73. (2) (b)]

4. The licensee has failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

On December 13, 2016, Inspector #148 entered the dining room on unit 2C at 0800 hours and noted resident #047 to be seated with puree prunes. The resident was provided feeding assistance at 0842 hours.

On December 13, 2016, Inspector #148 observed resident #021 to be served soup and meal at 1254 hours during the lunch meal service on unit 2C. Assistance was not provided to the resident until 1300 hours. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who require assistance with eating or drinking are not served their meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On December 12, 2016 at 0955 hours, Inspector #550 observed in hallway on unit 3A near nursing station in front of room #304 a medication cart left unattended. The medication cart was unlocked and on top of the cart there were two vials Insulin, one opened bottle of Lactulose labelled to resident #059, capsules of Spiriva and two bottles of isopto tears 1% eye drops. RPN #114 was in resident room #306 with the door halfway closed. The RPN was not able to see medication cart from inside the resident's room and there were resident wandering in the hallway. When approached by Inspector, RPN #114 stated she is unable to lock the medication cart as it locks on its own and that it takes a while before the cart locks itself. Inspector showed the RPN the medication that was left unattended on top of the cart and that the inspector was able to open all the drawers of the medication cart before she arrived.

During an interview, the Executive Director indicated to the inspector that if the nurse is unable to lock the medication cart by herself, she should stay with the medication cart until it locks on its own. The DOC indicated the RPN is able to lock the mediation cart by entering her code. She stated she should not leave her cart unlocked and leave medication on top when it is unattended. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all drugs are stored in an area or medication cart that are kept locked when unattended, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #011: On December 6, 2016, the black colored base of a piece of transfer equipment in the resident's room was noted to be covered in dirt and debris. On December 7, 2016, dust and debris were noted on the resident's wheel chair.

Resident #026: On December 6, 2016, dust and debris were noted on the resident's wheel chair.

Resident #027: On December 6, 2016, debris was noted on the lower part of the resident's wheel chair.

Resident #032: On December 6, 2016, debris was noted on the wheel chair frame and seat.

On December 14, 2016, the Supervisor of Auxiliary Services stated that ambulation equipment was cleaned twice per year by housekeeping staff. She stated that cleaning in between was done on an as needed basis with tickets logged through the central call system.

According to information provided by the Supervisor of Auxiliary Services:

Resident #011's wheel chair was cleaned on June 23, 2016 and in October 2016.

Resident #026's wheel chair was cleaned on August 26, 2016 and is scheduled to be cleaned in January 2017.

Resident #027's wheel chair was cleaned on August 18, 2016 and is scheduled to be cleaned this month.

Resident #032: unable to find a record of when the resident's ambulation equipment was cleaned, but is scheduled for cleaning this month.

Repeat observations completed on December 15, 2016, confirmed that the pieces of ambulation equipment remained in the same state of uncleanliness. [s. 15. (2) (a)]

WN #11: 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 protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff.

Sexual abuse is defined by the LTCHA, 2007 as ''any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; (''mauvais traitement d'ordre sexuel'')''.

This inspection is related to Log #027667-16.

A Critical Incident report was submitted to the Director by the licensee on a specific date in 2016 reporting an incident of resident to resident sexual. It was reported that on a specific date and time in 2016, resident #054 was left unattended for a couple of minutes and went into the dining room on unit 3AB naked and was asking two residents if they wanted to kiss him. One of the two residents was shaken by the incident.

Resident #054 was admitted to the home in 2015 with multiple diagnoses and he/she also has a known history of sexual abuse towards residents in the home.

During an interview, RPN #114 indicated that the morning of a specified date in 2016, the sitter who was to assume one on one duty with resident #054 for the day shift arrived at 0720. Upon her arrival, RN #103 who was assuming one on one supervision with the resident until the sitter's arrival left and informed the staff that she was now leaving. RPN #114 took the sitter aside to the report room which is located diagonally across the hall from resident #054's room to give her a short report since this sitter had never worked with resident #054 before. By the time she started giving the sitter her report, they heard resident #057 yelling from the dining room. When staff arrived in the dining room, they found resident #054 in front of resident #057 and #011's table naked, asking the residents for kisses. Resident #057 was shaken by the incident. The RPN immediately notified RN #103 of the incident by telephone. The RPN further indicated to the inspector that they are doing everything they can to prevent the resident from exhibiting inappropriate sexual behaviours but that there will be situations where they will not

be able to supervise the resident every seconds.

Inspector #550 reviewed resident #054's plan of care in place at the time of the incident. Interventions in place to manage the resident's inappropriate sexual behaviour were:
• advise DOC or RN immediately if inappropriate behavior seen.
• allow resident privacy when he/she is safely in his/her room.
• Constant supervision- resident has 1 on 1 on days and evenings and nights. When going on break, advise co-worker and ensure resident is in his/her room and monitored. Ensure reason for having a 1 on 1 is communicated to all staff every shift
• Ensure resident is not placed beside sspecific residents in unsupervised areas. When at mass or in DR ensure supervision
• Remove resident from public area when behavior is unacceptable.

During an interview, RN #103 indicated to the inspector that immediately after being informed of the incident by RPN #114, she sent an email to the Administrator/Clinical manager at 0750 hours describing the incident.

The Administrator/Clinical Manager indicated to the inspector that she read RN #103's email sometime in the morning on the date it was sent and replied to it at 0951 hours that same morning. She indicated she did not immediately report this incident to the Director as she was not sure that it was considered sexual abuse. The following day she decided to report the incident to the Director at 1155 hours as resident #057's substitute decision maker was upset and after thinking about the incident some more, she decided it would possibly be considered as sexual abuse.

This incident of sexual abuse was not immediately reported to the Director as identified in WN #4; the home's policy does not contain an explanation of the duty to protect under section 24 to make mandatory reports and the consequences for those who abuse and neglect residents as identified in WN #3 and the home's abuse policy was not followed as identified in WN#3. A Compliance Order under LTCHA, 2007, S.O. 2007, c.8, s. 19. was previously issued on June 27, 2015. The Compliance Order was re-issued and referred to the Director on September 30th, 2016, with a compliance date of December 30th, 2016. [s. 19. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receive individualized personal care, including hygiene care and grooming on a daily basis.

On December 6, 2016, Inspector #551 observed resident #009 to have long facial hair on his/her chin. Inspector #550 observed the resident again on December 16 and the resident still had long facial hair.

During an interview, PSW #119 indicated to Inspector #550 that resident #009's facial hair is removed when PSWs see that the resident has facial hair; it is not done on a regular basis. PSW #120 who is the PSW caring for the resident today indicated she did not notice the resident had long facial hair this morning. RPN #121 indicated to the inspector that resident's facial hair is to be shaved on bath days.

A routine sheet on the bulletin board in the report room on 3 AB titled "Routine ASS de bain 7h15-15-15" indicated to staff to see the list for baths and to cut and clean nails of non-diabetic residents. Shave male residents and female residents as required.

According to the resident's actual plan of care, resident #009 is to have a bath/shower on Sundays and Thursdays. PSW #119 indicated to the inspector that she is the one who gave resident #009'snbath the day before and she did not shave the resident because she did not have time. She indicated being aware that the bath routine posted in the report room for bath aides indicated to shave residents on bath days as required.

As evidenced above, resident #009 did not receive individualized personal care, including hygiene care and grooming on a daily basis. [s. 32.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #058.

Resident #058 has resided at the home since 2014. According to the resident's current written plan of care, he/she requires the assistance of two staff for all transfers.

The Administrator became aware of an allegation of staff to resident abuse on a specified date in 2016. The abuse is alleged to have occurred on the evening shift of another specified date in 2016, and involved resident #058 and PSW #139.

On December 22, 2016, the Administrator stated that PSW #139 was interviewed about the allegation of abuse on a specified date in 2016. During this interview PSW #139 recounted when he/she provided care to resident #058 on the evening shift of a specified date in 2016. The PSW stated that he transferred the resident by himself several times, despite the resident being a two-person transfer, including:

- At approximately 1645 hours, PSW #139 transferred resident #058 alone from his/her lazy boy chair to the toilet, then back to the lazy boy chair until approximately 1655 hours when he/he was transferred by one staff from the lazy boy chair to the wheel chair and brought to supper.
- At approximately 1815 hours, PSW 139 transferred resident #058 alone from the wheel chair to the lazy boy chair after supper.
- At approximately 1930 and 2030 hours, resident #058 was transferred by PSW #139 alone to and
from the lazy boy chair to the toilet.

The resident did not sustain an injury as a result of the unsafe transfer technique.

The Administrator stated that the resident should have been transferred with the assistance of two staff members as per his/her assessed need. [s. 36.]

WN #14: 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 has failed to ensure that resident # 038 was assessed when his weight changed by more than 5 percent (%) over one month.

Resident #038 was admitted to the home in 2016. He/she was ordered a low fat/cholesterol diet. On a specified date in 2016, the RD completed a Nutrition/Hydration Risk Identification Tool, and determined that the resident was at low risk.

During a specified period of time of one month in the summer of 2016, the resident's weight declined 7.7% (6.1kg). This was confirmed with re weights taken on two separate dates.

Resident #038's weight was assessed by the RD on a specified date in 2016; three months later. By this time the resident's weight had further declined by 1.2% (0.9kg) between two specified months and by 1.4% (1kg) between two other specified months. Resident #038's weight had declined 9.1% (7.2kg) between the onset of the weight loss and the RD assessment two months later. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

On December 13, 2016, Inspector #148 observed the breakfast meal service on unit 2C. At this service, residents arrived to the dining area at various times. At approximately, 0850 hours food items including puree oatmeal, puree bread, eggs, bacon and toast were plated for four residents. For resident #021 and #048 the plated food was set on the counter in the server. For two other residents, #049 and #050, the plated food was set at their place setting at the dining table. In the case for resident #049 and #050 dry cereal with milk were served prior to the residents' arriving to the table. The plated hot foods were observed to be held in the manner described above for 13-25 minutes. It was noted by the Inspector that the above meals were pre-plated for the residents as the Dietary Aide had removed herself and the hot food cart from the unit at approximately 0850 hours.

In addition to this, on December 13, 2016, Inspector #148 observed the lunch meal service on unit 2C. As described elsewhere in this report, the licensee did not ensure course by course service. It was noted that the main hot meal for resident #045 was held at the table for seven minutes without a heat source. The Inspector observed resident #045 to not consume all of the meal with approximately only 50% taken.

In this regard, food items for the above residents were not stored or served in a manner to preserve appearance and quality. [s. 72. (3) (a)]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

The licensee has failed to ensure that the advice of the Residents' Council and the Family Council, if any, is sought out in developing and carrying out the survey, and in acting on its results.

During an interview with the Resident Council president, it was reported that the survey had not been presented to the council for the purpose of seeking advice in the development and carrying out of the survey.

Inspector #148 spoke with the Resident Council liaison, staff member #135, who is present at each Resident Council meeting. After review of the council minutes, staff #135 reported she could not recall any time at which the survey was presented to the council for the purpose of seeking advice in the development and carrying out of the survey.

On December 16, 2016, the President of the Family Council was interviewed and stated that the licensee did not seek the advice of the Family Council in developing and carrying out the 2016 satisfaction survey as they had been in previous years.

Inspector #148 also spoke with the home's Executive Director who reported that the most recent resident and family satisfaction surveys were implemented in the summer of 2016 and it is to her knowledge that the councils was not presented with an opportunity to provide advice on the development and carrying out of the survey [s. 85. (3)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the final report to the Director, as described by section 104 of Regulation 79/10, shall be provide within 21 days.

Related to Log #028563-16

In accordance with section 23(2) of the LTCHA, section104 of the Regulation and Director's memo dated March 28, 2012, the licensee shall report to the Director the results of every investigation undertaken for the abuse of a resident by anyone within 21days of becoming aware of the incident.

On a specified date in 2016, the Administrator/Clinical Manager had received a report from RN #134 and subsequently interviewed resident #014. During the interview, the
resident reported to the Administrator/Clinical Manager that RPN#118 had told, in a threatening manner, that the resident was a racist and that no one likes the resident,
which caused the resident distress. Both the DOC and the Administrator/Clinical Manager began the licensee's investigation into the alleged verbal abuse incident. Inspector #148 confirmed with the home's DOC that the investigation was completed thirteen days after, at which time the RPN was brought back to regular duties in the
home. The investigation concluded that no abuse had occurred.

The Administrator/Clinical Manager submitted a report to the Director on the date the incident occurred, which included initial actions taken. The report was updated on a
specified date in 2016, thirty five days later, by the DOC, at which time the results of the investigation were reported. The licensee did not ensure that the results of the
investigation were reported within 21 days. [s. 104. (3)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition no later than one business day after the occurrence of the incident.

Related to Log #015156-16.

A report was made to the Director on a specified date in 2016, describing that resident #011 had fallen during the night shift of two days earlier. The report indicated that the resident had been sent out to hospital for assessment and returned on the same evening with a fractured body part.
These events were confirmed by the Inspector through staff interviews and the resident's health care record. In review of the resident health care record it was demonstrated that the care areas such as toileting, hygiene, transfers and locomotion were impacted by the injury.

The licensee did not report the occurrence of an incident that caused injury to resident #001 for which the resident was taken to hospital that resulted in a significant change in health condition no later than one business day. [s. 107. (3) 4.]

WN #19: 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. (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 has failed to 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.

During the resident observation on December 19, 2016, Inspector #551 observed that there were 3 inhalers and 1 tube of barrier cream on the bedside table in resident #024's room.

On December 19, 2016 at 1642 hours, Inspector #550 observed the following medication on resident #024's bedside table: three different inhalers and a specific spray medication.

During an interview, resident #024 indicated to the inspector he/she has been self-administering the inhalers for years and keeps them in his/her room.

The inspector reviewed the physician's orders in resident #024's healthcare records and was unable to find a physician order for self-administration of medication.

During an interview, RPN #114 indicated to the inspector that the resident self-administers the PRN inhalers and that she administers the inhalers that are prescribed on a regular basis naming a specific inhaler. Inspector showed the RPN that resident #024 had that specific inhaler in her room and that he/she had indicated to the inspector that he/she self-administers. The RPN was unaware that the resident had the specific inhaler in his/her room but was aware that the resident self-administered two of the other inhalers and the spray medication. She was not aware that the resident did not have a physician's order to self-administer the medication.

RN #103 indicated she was not aware that resident #024 did not have a physician order to self-administer his/her inhalers. [s. 131. (5)]

Issued on this 21 day of August 2017 (A2)

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JOANNE HENRIE (550) - (A2)

Inspection No. / No de l'inspection : 2017_619550_0004 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 013528-16 (A2)

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

Report Date(s) / Date(s) du Rapport : Aug 21, 2017;(A2)

Licensee / Titulaire de permis : BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET, OTTAWA, ON, K1N-5C8

LTC Home / Foyer de SLD : RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA, OTTAWA, ON, K1C-2Z6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Chantale Cameron

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

To BRUYERE CONTINUING CARE INC., 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. 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 :

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

The licensee is hereby ordered to complete the following:
1. The home must develop a "Bed System Assessment" safety questionnaire related to bed safety hazards to include all relevant questions and guidance related to bed safety hazards found in the: Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) recommended as the prevailing practice for
individualized resident assessment of bed rails in the Health Canada guidance document and Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards. The safety questionnaire shall, at a minimum, include questions that can be answered by the assessors related to: a. while the resident is sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period. 2. An interdisciplinary team shall assess all residents who use one or more bed rails using a "Bed System Assessment" safety questionnaire and document the results and recommendations for each resident and actions taken. 3. An interdisciplinary team shall re-assess all residents who use one or more bed rails if the resident's bed was changed and if any part of the bed was modified including the side rails or/and the mattress. 4.
Steps shall be re-taken to prevent resident entrapment, taking into consideration all potential zones of entrapment when resident's bed was changed and/or if any part of the bed was modified including the side rails or/and the mattress. 5. Develop and implement an education and information package for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, whether beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used,
(a) The resident is assessed and his or her bed system is evaluated in accordance with the evidence-based practices and, if there are none, in accordance with the 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.

On August 21, 2012, a notice was issued to 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" (HC Guidance Document). In the notice, it is written that this HC Guidance Document is expected to be used "as a best practice document". The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the HC Guidance Document are identified as ''useful resources'' and outline prevailing practices related to the use of bed rails.

Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (U.S., FDA). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including the resident's medical needs, sleep habits and patterns, sleep environment, resident comfort in bed, and potential safety risks posed by using one or more bed rails. The document indicates that if clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs, or a determination has been made that the risk of bed rail use is lower than that of interventions or of not using them, bed rails may be used. The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident medical record. The decision to use bed rails is to be approved by the

interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Residence Saint-Louis is a 198 bed home.

On December 6, 2016, Inspector #211 observed that resident #021's mattress was shorter than the deck of the bed frame and there was space between the mattress and the footboard. Inspector #211 informed the Executive Director that RPN #102 confirmed that the resident's bed had potential zone of entrapment (Zone 7) between the end of the mattress and the footboard. On December 6, 2016, Inspector #551 observed spaces between the end of the mattress and the headboard for residents #008, #011, #018 and spaces between the mattress and the footboard for residents #009, #014, #021, #036and #040. Resident #014 informed
Inspector #551 that his/her mattress was sliding and until he/she placed homemade bolsters at the end of the mattress and the footboard.

On December 7, 2016, Inspector #211 observed that the mattress was fitting the deck of the bed frame for resident #021 and there was no space between the mattress and the foot of the bed.

Inspector #211 observed that a plastic pad covered both elevated left half side rails. Inspector #211 was informed by the Coordinator of Auxiliary Services that resident #021's mattress and the bed frame were changed on December 6, 2016.

On December 7, 2016, Inspector #551 provided the list of the residents' names that were found with gaps between the end of the mattress and/or the head or the foot boards on December 6, 2016 to the Administrator/Clinical Manager.

On December 7, 2016, an email sent by the Administrator to the Executive Director and the DOC indicated that the administrator checked the six mattresses identified by inspector #511 as being too short for the residents' bed frame and acknowledged that the following residents' mattresses were too short:

- Resident #008`s mattress has 4 inches gap
- Resident #036`s mattress has 3 inches gap
- Resident #009`s mattress has 4 inches gap
- Resident #014`s mattress has 4 inches gap
- Resident #040`s mattress has 3 inches gap
- Resident #018`s mattress has 3 inches gap

•

On December 13, 2016, the Coordinator of Auxiliary Services provided the Fall 2015 bed audit list completed to Inspector #550. The document indicated that all the bed systems were assessed and given a failing grade, as one or more of the potential zones of entrapment failed the dimensional limit testing; therefore posing risks for entrapment. The audit indicated that the identified beds failed in different identified zones; respectively in zone 1, 2, 3, 4, 5, 6 and 7.

Review of the Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document) identified the different zones for entrapment as followed:
• Zone 1-Entrapment within the rail
• Zone 2-Entrapment under the rail, between the rail support or next to a single rail support
• Zone 3-Entrapment between the rail and the mattress
• Zone 4-Entrapment under the rail, at end of rail
• Zone 5-Entrapment between split bed rails
• Zone 6-Entrapment between the end of the rail and the side edge of the head or foot board
• Zone 7-Entrapment between head or foot board and the mattress end
On December 16, 2016, the Supervisor of Auxiliary Services provided a tracking list (revised on December 16, 2016). The list indicates that the home uses five different types of bed; Hill Rom Electric, Bertec Electric, DMI Electric, MC Healthcare, Arjo Low Bed Electric. It also identified 5 different types of bed rails currently used in the home.

The home's Audit 2015 and the Tracking bed system revised on December 16, 2016 indicated that the zones of entrapment for the following residents were:
• Resident #008's bed failed zone 2, 3, 6, and 7.
• Resident #009's bed failed zone 1 and 7.
• Resident #011's bed failed zone 4, 5, and 7.
• Resident #014's bed failed zone 6 and 7.
• Resident #018's bed failed zone 4 and 7.
• Resident #021's bed failed zone 2, 3, 4, 5, 6, and 7.
• Resident #036's bed failed zone 1 and 7.
• Resident #040's bed failed zone 2, 3, and 6.
•

Interview with the Supervisor of Auxiliary Services on December 14, 2016,

acknowledged that steps were not taken to prevent resident entrapment identified on the fall audit 2015.

Interview with the DOC on December 14, 2016, stated that the Coordinator of Auxiliary Services team in the home received bed entrapment training in the fall of 2015 by the Cardinal Health Company. They were told by the Cardinal Health Company that their education was based from the Canadian Entrapment Guideline.

Interview with the Coordinator of Auxiliary Services on December 15, 2016, indicated that all the beds in the home were assessed for entrapment zones by the Supervisor of the Auxiliary Services team. The tool to measure the beds' entrapment was borrowed from the Cardinal Health Company and the tool was sent back to the company after the beds were evaluated. The Audit of bed entrapment was completed in November 2015 and the audit indicated that all beds in the home failed one or more zones of entrapment. The home ordered 108 new mattresses on December 17, 2015, and the mattresses were received from January 19, 2016 to February 3, 2016. The 108 new mattresses were used to replace the old mattresses that the bed had failed the zone entrapment. The home ordered a second lot of 90 new mattresses on December 1, 2016 and the mattresses were received on December 6, 2016. A third lot of seven new mattresses were ordered on December 12, 2016 and received on December 14, 2016. The Coordinator of Auxiliary Services explained that the bed system was not evaluated after the old mattresses were replaced with the new mattresses to minimize risk of entrapment since the home doesn't have the measurement kit to assess entrapment.

Interview with the Coordinator of Auxiliary Services on December 15, 2016, stated that the licensee used one identified bed frame as a model and one of the new mattress received in 2016 to assess and to ensure that the zone 2 as identified as one of the most potential area for entrapment was resolved. The Coordinator of Auxiliary Services acknowledged that the above model was not sufficient to assess the risk of entrapment zones since the home has different types of bed frames and the mattresses received from January 2016 to December 14, 2016 were with different length.

On December 14, 2016, review of the health care record for the following residents indicated:
Resident #008 was admitted with several medical health issues. The resident`s current plan of care did not indicate that the resident was using side rails. The

resident`s MDS quarterly review assessment on a specific date indicated that the resident is not using the full or the other types of side rails. On December 15, 2016, resident #008 had the left full side rail elevated and the resident was not in bed. Interviews with PSW #123 and RPN #122 on December 15, 2016, indicated resident #008 was able to get out of the bed independently and the left full side rail placed beside the resident`s bedroom wall was to prevent the resident from falling between the bed and the wall.

Resident #009 was admitted with several medical health issues. The resident`s current plan of care did not indicate that the resident was using side rails. The resident`s MDS quarterly review assessment on a specific date in 2016, indicated that the resident is not using the full or other types of side rails. On December 15, resident #009 has the left full side rail elevated while the resident was lying in bed. Interview with resident #009 on December 16, 2016, indicated that he/she requested to have the left full side rail elevated for safety. Interview with PSW #119 on December 16,
2016, stated that resident #009`s left full side rail was elevated but usually the resident`s side rail is not elevated. Interview with RN #124 on December 16, 2016, stated resident #009`s left full side rail was elevated for safety and to prevent a fall. RN #124 indicated that the left full side rail should have been identified in the resident`s current plan of care.

Resident #011 was admitted in the home in 2016 with several medical health issues. The resident`s current plan of care indicated that the resident is using the two half side rails to assist with repositioning. The resident`s MDS on a specific date in 2016, indicated that the resident is using the full bed side rails every day. On December 16, 2016, resident #011 has both upper quarter side rails elevated in the resident`s bed. The resident was not in bed. Interview with PSW #119 on December 16, 2016, stated resident #011`s two upper quarter side rails are elevated during the night and when the resident was lying in bed. Interview with RN #124 on December 16, 2016, stated that the resident #011 used both quarter side rails for repositioning when he/she is in bed.

Resident #014 was admitted with several medical health issues. The resident`s current plan of care did not indicate that the resident was using side rails. The resident`s MDS quarterly review assessment on a specific date in 2016, indicated that the resident is not using the full or other types of side rails. On December 16, 2016, resident #014 has the right full bed side rail elevated while in bed. Interview

with resident #014 on December
15, 2016 indicated that he/she needs the right full bed side rail elevated when in bed. Interviews with PSW #119 and RN #124 on December 16, 2016, stated that the right full bed side rail is elevated as requested by resident #014 for personal reasons.

Resident #018 was admitted in the home in 2010 with several medical health issues. The resident`s current plan of care indicated that the resident needs to be turned and repositioned every two hours due to a decrease in mobility. The resident`s current plan of care did not indicate that the resident was using side rails. The resident`s MDS quarterly review assessment on a specific date in 2016, indicated that the resident is using the full bed side rails every day. On December 15, 2016, resident #018 had the left quarter side rail elevated beside the bedroom wall without the resident being in bed. Interview with PSW #130 on December 15, 2016, indicated resident #018 was using the left quarter side rail placed beside the resident bedroom wall when he/she was in bed for repositioning.

Resident #021 was admitted with several medical health issues. The resident`s current plan of care did not indicate that the resident was using side rails. The resident`s MDS quarterly review assessment on a specific date in 2016, indicated that the resident was not using the full or other types of side rails. On December 15, 2016, resident #021 has the two left quarter side rails elevated covered with a plastic bumper. Interviews with
PSW #131 and RPN #105 on December 16, 2016, stated that resident #021`s four quarter side rails on each side of the resident`s bed were elevated during the night to prevent the resident from falling. PSW #131 indicated that the left two quarter side rails were put down after she had transferred the resident from the bed to the wheelchair. The bumper cover on the two left quarter side rails was to prevent the resident from hitting his/her legs on the left side rails.

Resident #036 was admitted with several medical health issues. The resident`s current plan of care did not indicate that the resident was using side rails. The resident`s MDS annual assessment on a specific date in 2016, indicated that the resident is not using the full or other types of side rails. On December 15, 2016, resident #036 had the left half quarter rail elevated without the resident being in bed. Interviews with PSW #123 and RPN #122 on December 15, 2016, stated resident #036 was able to get out of her bed independently and the left quarter side rail was elevated
beside the resident`s wall to prevent the resident from falling between the bed and

the wall.

Resident #040 was admitted with the diagnosis of dementia and other health issues. The resident`s current plan of care indicated that the resident is using her bed rails and staff need to cue resident for repositioning. The resident`s MDS quarterly assessment on November 22, 2016, indicated that the resident is not using the full or other types of side rails. On December 15, 2016, resident #040 had the left full side rail elevated beside the resident`s bedroom wall while the resident was in bed. Interview with PSW #125 on December 15, 2016, stated that resident #040 was using both full side rails when in bed to prevent a fall.

Observation and review of the above residents' health care record, their current plan of care and their most recent quarterly assessment (MDS) indicated that there was conflicting information relating to the use of side rails.

Review of the Supervisor of Auxiliary Services list on December 19, 2016, indicated the beds and/or the mattresses were changed on the following dates:
• Residents #008, #009, #036, and #040's mattress was replaced between December 7, 8, 9, 2016
• Resident #011's mattress was replaced on December 15, 2016
• Resident #014's bed frame and a 84 inches mattress was replaced on December 14, 2016
• Resident #018's 84 inches mattress was replaced on December 15, 2016
• Resident #021's mattress was replaced on December 6, 2016 and the bed frame was replaced on December 7, 2016 because the mattress was too short.

On December 14, 2016, the Administrator/Clinical Manager and the Supervisor of Auxiliary Services on December 14, 2016, revealed after changes were made to the above identified bed systems, steps were not taken to assess the new bed system. The bed system was not evaluated because the home does not have the measurement kit to assess the potential zone of entrapment. The Executive Director indicated that the home was presently in the process of ordering the measurement kit to assess all the beds in the home.

Over the course of the inspection and interview with the Coordinator of Auxiliary Services on December 15, 2016, it was identified that after the Audit in 2015, when changes were made to a resident's bed systems such as a change of mattress or bed rails from January 2016 to December 14, 2016, the home did not have a process

in place to ensure that the resulting new bed system was evaluated in accordance with evidence based practices since the home did not have the entrapment assessment tool to minimize risk to the resident.

Interview with the Supervisor of Auxiliary Services on December 19, 2016, confirmed that the tracking list system reviewed on December 16, 2016, does not identify the date when the old mattress was exchanged for a new mattress for each beds during the period from January to December 2016, excluding the recent beds from December 7 to December 15, 2016. The tracking system does not identify the dates of side rails modifications. The process does not keep a track of residents internal transfers and if the bed systems were changed.

On December 19, 2016, the DOC and the Executive Director acknowledge that the licensee doesn't have the following practice:
• to evaluate resident's bed system where bed rails are used to minimize risk to the resident,
• education for staff to evaluate resident's bed system where bed rails are used to minimize risk to the resident, and
• information packages for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, whether beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails.
•
The severity of harm related to resident's bed assessment and risk of potential zone of entrapment was determined to be "potential for actual harm". The scope was identified as "widespread" as the residents using bed rails were not assessed, neither was the bed systems evaluated and steps were not taken into consideration to prevent resident entrapment. (211)

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

Oct 13, 2017(A2)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 21 day of August 2017 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JOANNE HENRIE - (A2)

Service Area Office /
Bureau régional de services : Ottawa