Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 9, 2017 | 2017_548592_0021 | 004061-17, 009996-17, 011815-17, 016390-17, 016391-17, 016396-17, 016398-17, 016399-17, 016401-17 | Follow up |

**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**

MELANIE SARRAZIN (592), JOANNE HENRIE (550)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): October 05, 06, 10, 11, 12, 13, 16, 17, 18, 19 and 20, 2017**

**This inspection was conducted to follow on seven orders (CO)**

**CO #001, Log # 016401-17, previously issued on June 28 and amended on July 18,**

**2017.**
**The Compliance Order was issued as a result of non-compliance related to elevators in the home not equipped to restrict resident's access to the basement level.**
**CO #002, Log # 016398-17, previously issued on June 28 and amended on July 18, 2017.**
**The Compliance Order was issued as a result of non-compliance related to plan menu items not offered and available at each meals and snack.**
**CO #003, Log # 016396-17, previously issued on June 28 and amended on July 18, 2017.**
**The Compliance Order was issued as a result of non-compliance related to the written policy to minimize the restraining of residents.**
**CO #004, Log # 016391-17, previously issued on June 28 and amended on July 18, 2017.**
**The Compliance Order was issued as a result of non-compliance related to Director of Nursing and Personal Care.**
**CO #005, Log # 016390-17, previously issued on June 28 and amended on July 18, 2017.**
**The Compliance Order was issued as a result of non-compliance with the care plan for residents.**
**CO #006, Log # 016399-17, previously issued on June 28 and amended on July 18, 2017.**
**The compliance order was issued as a result of non-compliance related to assistance with eating and drinking at meal time.**
**CO #001, Log # 004061-17, previously issued on June 28 and amended on July 18, 2017.**
**The compliance order was issued as a result of non-compliance related to bed rails system.**

**The following critical incident and complaint inspections were as well completed during this follow-up inspection: Log # 009996-17, #011815-17 and #013845-17.**

**During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Volunteers, Housekeeping Aide, Dietary Aids, Personal Support Workers (PSW), Registered Practical Nurses (RPN),Registered Nurses (RN), Occupational Therapist (OT), Environmental Service Supervisor, Dietitian, Food Service Manager, Resident Care Coordinators, Assistant Director of Care (ADOC), Director of Care (DOC) and the Administrator/Executive Director.**

**During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, relevant licensee policies and procedures regarding fall prevention and minimizing of restraints and documents pertaining to bed systems maintained in the home and resident assessments related to the use of bed rails, posted menus, observed resident rooms, resident common areas, meal service, the delivery of resident care and services and staff to resident and resident to resident interactions.**

**The following Inspection Protocols were used during this inspection:**
**Dining Observation**
**Falls Prevention**
**Minimizing of Restraining**
**Personal Support Services**
**Safe and Secure Home**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **5 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 10. | WN | 2017_618211_0008 | 592 |

| | | | |
|---|---|---|---|
| O.Reg 79/10 s. 10. (1) | CO #001 | 2017_618211_0008 | 592 |
| O.Reg 79/10 s. 24. | WN | 2017_618211_0008 | 592 |
| O.Reg 79/10 s. 24. (2) | CO #005 | 2017_618211_0008 | 592 |
| LTCHA, 2007 S.O. 2007, c.8 s. 29. (1) | CO #003 | 2017_618211_0008 | 550 |
| LTCHA, 2007 S.O. 2007, c.8 s. 71. | WN | 2017_618211_0008 | 592 |
| LTCHA, 2007 S.O. 2007, c.8 s. 71. | CO #004 | 2017_618211_0008 | 592 |
| O.Reg 79/10 s. 73. | WN | 2017_618211_0008 | 592 |
| O.Reg 79/10 s. 73. (2) | CO #006 | 2017_618211_0008 | 592 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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,
(b) Steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment;

The home was noted to be non-compliant with O.Reg s. 15. (1), where bed rails are used in the home, during the Resident Quality Inspection conducted on April 18, 2017. A compliance order was issued with a compliance date of May 30, 2017. The home was granted as per their request an extension with a new compliance date for August 31, 2017. In addition, as per their request, the home was granted a second extension with a new compliance date of October 13, 2017.

It is to be noted that the order contained five criteria for the licensee to meet.

Criteria 1a and 1b was to develop a "bed System Assessment" safety questionnaire related to bed safety hazards including 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 was required to contain questions which would be answered by the assessors related to: a. while the resident was 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.

Criteria 2 was to have an interdisciplinary team to assess all residents identified with one or more bed rails using a ''Bed System Assessment'' safety questionnaire and to document the results and recommendations for each resident and actions that were taken.

Criteria 3 was for the interdisciplinary team to re-assess all residents who were using 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.

Criteria 4 was that steps and/or re-taken by the home to prevent resident entrapment by taking into consideration all potential zones of entrapment when resident beds were changed and /or if any part of the bed was modified including the side rails or/and the mattress.

Criteria 5 was to develop and implement education and information package for staff, families and residents by 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.

Criteria 1a and b, 2, 3 and 5 were met by the licensee.
Criteria 4 was not met by the licensee as per the following described below;

A follow-up inspection to the order was conducted on October 18, 2017.

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.

In an interview with the Administrator on October 18, 2017, she indicated to the Inspector that following the Resident Quality Inspection, the home has created a "Bed System Assessment" safety questionnaire related to bed safety hazards which included relevant questions and guidance related to bed safety hazards and that all the residents were assessed using a form titled "Resident and Bed System Safety Assessment located in the home's software system. The Administrator further indicated that when a new resident is admitted, a bed is provided to the resident with no rails until the resident and bed system safety assessment is completed. She further indicated that following the results of the assessment, specific alternatives and equipment required will be based on the resident's individual needs. The Administrator also indicated that additional

information related to changes done to the resident's bed as well as family concerns and authorization would be found in the resident's progress notes as needed. During the interview the Administrator indicated that 198 beds were evaluated and tested for entrapment hazards zones and that some beds were discarded following the results of the test and a total of 67 beds were purchased to replace them. She further indicated that education was provided to the staff, the residents and the family members to identify the regulations and prevailing practices governing adult hospital beds, the risk of bed rail use, whether beds pass or fail entrapment zone testing.

The Home's Coordinator of Auxiliary Services provided to the Inspector a spread sheet for the tracking of the tested beds and entrapment zone testing. The spread sheet identifies 198 beds with room numbers, resident names, bed numbers, type of beds, type of rails used, zone of entrapment (Pass or failed), type of mattress, comments, reassessment and pre-admission follow-up. The Coordinator indicated that the letter F was the coding used to indicate a fail to a specific zone of entrapment. She further indicated that if the boxes were left empty to the section of the zones area, it meant that the zone had pass.

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.

During a review of the home's tracking sheet, it was noted that 16 beds were identified with the letter F in boxes related to the assessment (Pass or Fail) of zones of entrapment.

The spread sheet indicated that:
Five beds were identified with the letter F for zone 7

Four beds were identified with the letter F for zone 6
One bed was identified with the letter F for zone 3
Nine beds were identified with the letter F for zone 2
One bed was identified with the letter F for zone 1

The spread sheet also identified that the home has eight therapeutic air surfaces in use with empty boxes under the risk of entrapment zone indicating that the zone of entrapment had pass.
As per the Health Canada guidance document, bed systems with therapeutic air surfaces are exempt from the prescribed testing for zones 2-4 due to the highly compressible nature of the mattresses.

On October 19, 2017, Inspector #592 did a review of the health care record for three residents identified with failed zone of entrapment.

Resident #028's bed was identified with failed zone 1, 2, 3 and 6.

Resident #028 was admitted in 2015 with several diagnosis such as arthritis and depressive episodes. The Resident and Bed System Safety Assessment completed on a specified date, indicated that the resident has a specified high low bed in place with four bedrails of which the resident only use one quarter rail. The Resident and Bed System questionnaire further indicated that question #2 which is to assess the level of risk for side rails and injury, was documented as a "yes" for the resident to suffer from agitation, have epilepsy or other involuntary movements, which may cause entrapment. The current plan of care indicated that the resident chooses to keep rails for own sense of security buy using one ¼ rail and leaving the other three ¼ rails down.

On October 20, 2017, Inspector #592 observed the resident #028's bed with one ¼ rail up . The rail was observed with a gap of five inches between the frame of the bed and the rail (zone 2)

Resident #027's bed was identified with failed zone 2.

Resident #027 was admitted in 2016 with several diagnosis such as diabetes mellitus and dementia. The Resident and Bed System Safety Assessment completed on a specified date, indicated that the resident has a specified high low bed in place with two quarter side rails at the head of the bed to assist resident. The Resident and Bed System

questionnaire further indicated that question #2 which is to assess the level of risk for side rails and injury, was documented as a "yes" for the resident to suffer from agitation, have epilepsy or other involuntary movements, which may cause entrapment. The Resident and Bed System questionnaire further indicated that question #2 under bed system and sleep evaluation, that the resident suffers from a sleep disturbance. The current plan of care indicated that the resident has two full bed rails to assist with mobility and safety, requested by the resident and the Substitute Decision Maker (SDM).

Resident #029's bed was identified with failed zone 2.

Resident #029 was admitted in 2012 with several diagnosis such as fibromyalgia and osteoporosis. The Resident and Bed System Safety Assessment completed on a specified date indicated that the resident has a specified high low bed in place with one full side rail. The Resident and Bed System Safety Assessment further indicated that the resident was made aware of the entrapment risk with the one full side rail following the results of the bed assessment but the resident still expressed to keep the full rail in place.

Upon a review of the current plan of care for the three residents above, no interventions, steps and actions were found to prevent resident's entrapment to the identified zones.

On October 20, 2017, in a discussion with the Administrator she indicated that she was made aware of the results of the bed system evaluation and the beds flagged with failed zones of entrapment. The Administrator further indicated that there was no formal process in place to prevent resident's entrapment with regards to the beds identified with failed zones of entrapment. She further indicated that the home has retested the beds identified with failed zones and was able to do some modifications as well has having discussion with the residents and the family members exposing the risk of entrapment by keeping the rails and that a result of the discussion was kept in the resident health care records. At the time of the inspection, the home was actively working to put steps in place to prevent resident's entrapment. [s. 15. (1) (b)]

***Additional Required Actions:***

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

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**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 the planned menu items are offered and available at each meal and snack.

This inspection is a follow-up inspection for CO #002, issued on June 28, 2017 with a compliance date of September 28, 2017.

On October 5, 2017, Inspector #550 observed the lunch meal service in a specified unit dining room at 1200hrs. The menu choices for desert according to the week 3 therapeutic diets, Spring-Summer menu day 18 which was posted in the hallway at the dining room entrance were:
Date squares for regular and soft textured diets and ice cream for mince and puree textured diets
Diced peaches for regular and soft textured diets and pureed peaches for the puree and mince textured diets.

The residents were offered date squares, diced peaches, yogurt and red Jello as per items available on the desert cart. Inspector #550 noted that the ice cream for mince and puree textured diets was not offered to any of the residents. Dietary Aid #110 indicated to the inspector that the ice cream was not put on the desert cart as this item requires to be frozen. It was available in the refrigerator in the servery and PSWs had to get it from the freezer. PSW #111 indicated that she was not aware that ice cream was on the menu for that meal.

On October 6, 2017, inspector observed the breakfast and lunch meal services on another unit.
The breakfast and lunch menu posted in the dining room indicated:

Breakfast:
Banana

Prunes/puree
Cream of wheat
Cold cereals
Various toasts
Scrambled eggs

Lunch:
Pea soup/pureed celery soup
Tomatoes and cucumbers with vinaigrette/Pureed green salad
Assorted sandwiches (egg/ham)/Pureed veal
Breaded lemon pepper fish/mashed fish without the breading/pureed fish
Carrots/chopped carrots/pureed carrots
Mashed potatoes
Sweet potatoes fries
Strawberry shortcake
Pureed strawberries
Bananas/individual pureed fruits

Resident #010 was served a plate with scrambled eggs, two cut up toasts and sliced bananas after he/she ate his/her cereal at breakfast. Other food choices were not offered. At lunchtime, the resident was served a plate with 3 pieces of sandwiches, mashed potatoes with gravy and carrots, food choices were not offered. Inspector reviewed the resident's kardex at point of service and it did not indicate that this resident was not to be offered food choices.

Resident #011 was fed hot cereals, pureed bread and pureed eggs for breakfast. The resident was not offered or provided with bananas or prunes as per the planned menu. Inspector reviewed the resident's kardex and it did not indicate that the resident was not to be provided with fruits at breakfast.

Resident #012 was given a plate containing eggs and cut up toast with jam for breakfast. The resident was not provided with or offered cereal or fruit as per the planned menu. The inspector reviewed the resident's kardex which did not indicate that the resident is not to be given any cereal or fruit at breakfast or that this resident was not able to make food choices.

Resident #013 was fed cream of wheat, pureed bread and pureed eggs for breakfast. The resident was not provided with fruits as per the planned menu. The inspector

reviewed the resident's kardex which did not indicate that the resident was not to be given fruit at breakfast.

PSW #102 attempted to feed hot cereals in a glass with a straw to resident #014 at breakfast which the resident refused. RPN #109 then gave PSW #102 a glass with a straw which she later indicated to inspector contained a food supplement mixed with milk. The resident consumed all of the milk with the food supplement. The resident was not offered or provided with other food items on the menu after he/she refused to eat the cereal. RPN #109 indicated to the inspector that this resident often does not eat and thus the reason for giving the food supplement. She further stated that when the resident refuses to eat his/her cereals, he/she always refuses everything else therefore there is no use offering him/her the other food items and that the resident has always been this way. Inspector reviewed the resident's kardex and it did not indicate that the resident was not to be offered other food items when the resident does not eat or that the resident was not able to make food choices.

At 0925hrs, resident #015 arrived in the dining room for breakfast and resident #016 who had previously refused to eat had decided he/she was ready to eat. By this time the food cart containing the hot food items had already left the unit and there was no hot food items to offer the two residents. PSW #111 gave both residents cold cereal with milk and informed the inspector that she was going to make them toasts in the servery. She stated that she was not able to offer the eggs and hot cereals as the hot food cart was already gone.

Resident #008, #009 were not offered or provided with pureed green salad at lunchtime as per their therapeutic diet as there was none left. Inspector #550 observed that none of the residents in the dining room were offered bananas, which was one of the food items' identified on the menu for the dessert at lunchtime. PSW #111 and RPN #109 indicated to the inspector that they were not aware that bananas were on the menu for desert as they had not looked at the menu, furthermore indicating that there were no bananas available on the desert cart. The RD who was in the dining room at the time, showed the employees that the bananas were on the top of the cart used to transport the desert from the kitchen to the servery which was located in the servery. This cart is where PSWs get the plated desert to put out on the desert cart and offer to residents.

On October 10, 2017, inspector #550 observed the breakfast meal service on another unit.
The posted menu for breakfast:

Mandarin, pureed prune
Oatmeal
Cold cereals
Toasts
Scrambled eggs

Resident #017 was served a plate containing toasts with peanut butter and scrambled eggs by D.A. #110. The resident was not offered food choices, cereal and fruit.
Resident #018 was served coffee and toast by D.A. #110. The resident was not offered food choices, fruit, cereal or eggs.
Resident #019 was served toast, hot cereal and cranberry juice. The resident was not offered food choices, fruits or eggs.
Resident #020 was served cranberry juice, bran flakes in milk, toast and eggs. The resident was not offered food choices or fruits.

These four residents were not offered food choices as per the planned menu. Inspector reviewed the kardex at point of service for all four residents and it did not indicate that these residents were not to be offered the planned menu items or that these residents were not able to make food choices.

At 0920hrs, Inspector observed that the residents were not offered any fruit as per the menu excepted for three residents who were served prunes. During an interview, D.A. #110 indicated to the inspector that the menu indicated mandarins but that he did not have any that morning as the order had not been placed last Thursday. Because of the long weekend, the mandarins were not delivered to the home. He explained that he only had three servings of prunes as only the same three residents take prunes every morning. Inspector asked if the pureed prunes were available as per the menu for the residents. The D.A. further indicated that the residents in the small dining room do not need to take prunes as they have no problems with their bowel movements. At 0945hrs, the FSM #121 brought mandarins to the unit. At this time, there were only 5 residents left in the dining room eating breakfast, all the others had finished their breakfast and returned to their room. She indicated to the inspector she had been made aware by the Administrator/Executive Director that mandarins were not available on the unit although they were on the menu. The mandarins were available and should have been brought to the unit by the D.A. #110 at the same time he brought his food cart. She further explained that even though prunes were on the daily breakfast menu, they are not provided to all residents on a daily basis; there are only three specific residents to which prunes are given daily. Prunes are provided to the other residents according to a

schedule she has in her office.

At 0955hrs, resident #021 was brought by staff for breakfast and was served a regular yogurt, mandarins, eggs and toasts. The resident was not offered cereals as per the planned menu. D.A. #110 indicated to the inspector that this resident never takes cereal therefore it is not offered. Inspector reviewed the resident's kardex and it did not indicated that cereal are not to be offered to this resident or that the resident cannot make food choices.

During an interview on October 26, 2017, D.A. #110 indicated to the inspector that residents who cannot make food choices are served as per their likes and dislikes documented in their kardex at point of service and that he knows what the residents prefer to eat as he has worked there for many years. Resident #017 does not take any cereal in the morning, resident #018 is provided with cereal, fruit and eggs only if there is a staff member available to feed him/her these items, resident #019 does not like mandarins and eggs and resident #020 does not eat fruits in the morning.

During an interview on October 10, 2017 with the Registered Dietician, the two Food Service Managers, the Director of Care and the Executive Director they indicated to the inspector that all the food items on the planned menu are to be offered to all residents including modified texture diets.

As evidenced above, the planned menu items were not offered and available to each resident at each meal and snack.

Non compliance was previously issued as a compliance order (CO) on June 28, 2017, with a compliance date of September 28, 2017 under inspection #2017_618211_0008. A voluntary plan of correction (VPC) was issued on February 22, 2017, under inspection #2017_619550_0003. A voluntary plan of correction (VPC) was issued on February 16, 2017, under inspection #2017_619550_0004. A voluntary plan of correction (VPC) was issued on July 29, 2016, under inspection #2016_289550_0023. A voluntary plan of correction (VPC) was issued on January 21, 2016, under inspection #2015_289550_0027. [s. 71. (4)]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (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. (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).**

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. 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.

On several dates in October 2017, inspector #550 observed meal services in two dining rooms.

Resident #022 was provided with 2 pieces of sandwiches, carrots and mashed potatoes at lunch. The Registered dietician indicated to the inspector that a portion of sandwiches is three to four pieces of a sandwich and that the resident should have been given at least three pieces of sandwiches. The inspector reviewed the resident's kardex at point

of service and noted that it did not indicate that the resident was to have smaller portions. The last nutrition risk assessment completed by the R.D. on a specified date in 2016, identified the resident to be at a high nutritional risk because the resident was refusing meals.

Resident #010 was served three pieces of sandwiches, mashed potatoes with gravy and carrots in a regular plate and was eating with regular utensils. The inspector reviewed the resident's kardex at point of service which indicated that resident #010 required a specific therapeutic diet with specific eating aids to eat. The R.D. indicated to the inspector that the resident should not have received the potatoes with the gravy because of the diet requirements and that the resident should have been provided with specific eating aids. Dietary aide #112 indicated to the inspector and the R. D. that she served resident #010 and she did not verify his/her kardex prior to serving the resident and was not aware of the diet requirements. The FSS later indicated to the inspector that she was not made aware that resident #010 required specific eating aids, therefore there were none available on that specified unit dining room.

Resident #008 was observed on two specific dates in October by inspector #550 sitting in a wheelchair in the dining room, being fed by PSW #108. The resident's kardex indicated resident #008 required to be positioned with specific instructions and equipment which the resident did not have in place during the three observations made by the inspector. During an interview, PSW #108 who was the PSW who fed the resident all three meals observed, indicated to the inspector that he was not aware if the resident still required to be positioned with specific instructions and equipment when being fed in the dining room. He then got up and went to get the specific equipment.

Resident #017 was served toasts with peanut butter and scrambled eggs in a regular plate and a glass of orange juice by D.A. #110 for breakfast. The resident's kardex at point of service indicated that the resident required food to be served in a specific eating aid device with specific likes and dislikes for breakfast. During an interview, D.A. #110 indicated to the inspector that the resident never eats cereals in the morning and that the specific eating aid device was for lunch and dinner only. He also added that one of the food item that the resident likes was not available and that often it was not available.

Resident #018 was served toasts in a regular plate by D.A. #110. The resident's kardex indicated that the resident required to have a specific eating aid device. D.A. #110 indicated to the inspector on October 26, 2017 that the eating aid device was only for lunch and dinner meals.

During an interview, the R.D. indicated to the inspector that the kardex at point of service is the tool used by D.A. and PSWs when serving the residents. The kardex will identify the resident's diet and texture type, the fluid consistency and directions specific to each resident for mealtime such as likes and dislikes, food allergies, if the resident is able to make food choices. All residents who are identified as requiring eating aids are to be provided with the eating aid specified in their plan at every meal.

As evidenced above, the care set out in the plan of care was not provided to residents #022, #010, #008, #017 and #018 as specified their plan. [s. 6. (7)]

2. The licensee has failed to ensure that the plan of care was reviewed when the resident's care needs change or care set out in the plan is no longer necessary.

While conducting a follow-up inspection on side rails and bed entrapment, Inspector #592 noted that resident #027 was identified using two full side rails with a failed of zone 2 for risk of bed entrapment.

A review of resident #027's health care record was done by Inspector #592 which indicated that the resident was admitted to the home in 2016 with several diagnosis such as diabetes mellitus and dementia.

The current written plan of care for resident #027 under bed mobility indicated that the resident moves in bed with assistance of bed rails and one staff member. The interventions further indicated that the resident has two full bed rails to assist with mobility and safety requested by the resident and the substitute decision maker (SDM) as a Personal Assistive safety Device (PASD).

Resident #27's progress notes were reviewed by Inspector #592 and the following were documented in the progress notes:

On a specific date, it was documented that resident #027 had fell the night before which caused an injury to specific body areas. The progress notes further indicated that resident #027 was sent to the hospital to be treated. It is further documented that the resident told the staff members that he/she fell out of his/her bed because he/she thought that he/she could walk on his/her own. The progress notes indicated that the rails had been removed prior to the fall as per the home's side rails program but that following the fall, the rails would be put back on.

On October 19, 2017, Inspector spoke with resident #027 who indicated upon being asked about the purpose of the rails that he/she has both of them up when he/she is in bed and would like them to be put down as he/she was unable to get out of bed and would need both of them down in order for him/her to pick things on the floor. She further indicated that he/she was not given the permission to put the rails down and asked the Inspector if she could do something about it. When Inspector inquired about the rails being used to help him/her mobilized in bed, the resident told the Inspector that he/she was unable to mobilize with the rails in bed and was depending on the staff members for repositioning.

On October 19 and 20, 2017, in an interview with PSW #119 and #116, both PSWs indicated that resident #027 was unable to use the side rails while in bed due to physical limitations, therefore resident #027 was depending on two staff for repositioning. They both further indicated that the two full side rails were put in place for safety to avoid the resident from falling from bed and that it was also a request by the resident's family member for the resident's safety.

On October 20, 2017, in an interview with the DOC, she indicated to the Inspector that resident #027 was assessed on a specified date and that at that time, the resident was able to mobilized and assist staff in bed for repositioning, therefore ¼ rails were put in place. She further indicated that when the incident of the fall occurred , the family had requested to have two full side rails in place which was done and were still used as a PASD. The DOC further indicated that she was not aware that the resident had a significant change in his/her physical condition inhibiting the resident from using the rails when being repositioned in bed. She further indicated that the care plan for resident #027 should have been revised when the resident was no longer able to use the rails to mobilize in bed. [s. 6. (10) (b)]

3. The licensee has failed to ensure that the resident was reassessed and his/her plan of care was reviewed and revised at least every six months and at any other time when, c) Care set out has not been effective.

Resident #025 was admitted to the home in 2002 and was diagnosed with multiple health conditions including dementia and osteoporosis. The resident was observed self-propelling on the unit in a wheelchair at various times and days and had a specific safety device in place. According to interviews with staff and the documentation in the progress notes, the resident is to have a different safety device in place to prevent falls and is

identified as a frequent faller.

During a review of the resident's health care records, inspector #550 noted documented in the progress notes that the resident had seven falls in a three month period. The documentation indicated that six out of the seven falls occurred when the resident was in bed and attempted to get out of bed on his/her own. There were also five "safety concern" events documented in the progress notes for that same period of time where the resident was found by staff attempting to get out of bed on his/her own but had not fallen.

During an interview, RPN #109 indicated to the inspector on October 18, 2017, that the resident's falls occur mostly when the resident is in bed and attempts to transfer himself/herself from the bed. The resident does not remember he/she can no longer walk on his/her own. She indicated that the interventions in place to prevent the resident from falling are to have a safety device while in his/her wheelchair and fall mat on the floor in front of the resident's bed when he/she is in bed.

A review of the written plan of care and the documentation in the health care records revealed that new interventions were put in place to prevent the resident from falling when he/she is sitting in his/her wheelchair. There were no new interventions to prevent the resident from falling from his/her bed added to her plan of care until 20 days after the fifth fall. The new interventions were:
1. assess for the correct bed height and mark bed height with tape to demonstrate to all staff
2. call bell within reach of chair

The inspector observed the resident's room and was not able to find any marking on the walls in the resident's room to indicate the proper height the bed should be. The resident was sitting in a wheelchair in front of the bedrail where the call bell activation cord was visibly located. When questioned, the resident indicated to the inspector he/she did not know where the call bell was located. The inspector showed the call bell activation cord to the resident and the resident indicated he/she did not know what this was. After explaining to the resident that it was the call bell that he/she could use it to call when he/she needed help and showing the resident how to use it, the resident was still not able to use the call bell.

On October 16, 2017, during an interview, RN #114 who is the full time RN for this unit indicated to the inspector that she did not know what other interventions could be put in

place to prevent residents from falling. When they complete a post-fall assessment, there are no other interventions they can select from the drop down menu in PCC and the home does not use hip protectors or bed alarms. She further indicated that they cannot stop residents from falling and that the Ministry should give more money to the homes to be able to put more interventions in place.

During an interview on October 18, 2017, the Director of Care indicated to the inspector that resident #025's bed height was not assessed and marked with the tape as identified in his/her plan of care. The resident was not able to use the call bell therefore this intervention should not be in the plan of care. Furthermore, she indicated that registered staff should personalize the residents' plan of care when assessing a resident and that other interventions can be manually added in the "other" box in PCC.

As evidenced above, resident #025 was not reassessed and the plan of care was not reviewed and revised when the care set out in her plan was proven to be ineffective. [s. 6. (10) (b)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

This inspection is related to Log #009996-17 involving resident #007 and multiple falls in the home.

A review of resident #007's health care records on October 12, 2017 by Inspector #592 revealed that resident #007 was admitted on in 2017 with several diagnosis such as dementia, Parkinson's disease and peripheral vascular disease.

The progress note indicated that the main reason for the admission of the resident was that the resident was requiring total dependence for mobility and transfers which was worsening over his/her previous state where he/she was not wheelchair dependent but was found to wander and leave without warning. The progress notes also indicated that the resident was identified at being at high risk for falls due to one or more falls in the last three months previous to his/her admission to the home.

The plan of care was reviewed by the Inspector and the goals and interventions put in place at the time of the admission under high risk for falls for resident #007 were to:

-Provide resident #007 with one staff assistance during the transfers.
-Call bell within reach of bed and chair.
-Ensure appropriate daytime lighting
-Ensure night light on at all times
-Reinforce need to call for assistance
-Transfer and change position slowly
-Ensure resident uses assistive devices (wheelchair)
-Resident to wear proper and non-slip footwear
-Environmental modifications to reduce fall risk

The progress note indicated that resident #007 fell seven times within a 29 day period.

Five days after the resident's admission, the resident was found on the floor in front of his/her bathroom when he/she attempted to go to the bathroom on his/her own and lost balance. The progress notes indicated that the resident voiced to the nursing staff that he/she had hit a specific body part.

Four days after the first incident, the resident had a fall but no other documentation was found. It is therefore unknown if the resident has sustained an injury or if any other interventions were put in place.

Ten days after the second incident,  documentation was found dated from a late entry 16 days after for a fall which had occur, where the resident was found sitting on the floor beside a resident bed. The resident indicated that he/she was trying to transfer from the chair into the bed. No injury to the resident.

Nine days after the third incident, the resident was found in his/her room on the bathroom floor. Redness was noted to specific body areas.

The day after, the resident had a fall with the presence of one PSW who was providing the resident with assistance which was refused by the resident who attempted to transfer on his/her own and lost his/her balance. No injury to the resident.

On the next day, the resident was found in his/her room on the floor. The resident was attempting to get in/out of chair. The resident was complaining of pain to specific body areas with a skin tear where dressings were required.

Three days after, the resident was found in his/her room on the floor laying on his/her

back. The resident was attempting to get in/out of chair. No injury to the resident.

The care plan in place at the time of the resident's falls was reviewed.
It is documented that the plan of care for resident #007 was not reviewed until the third fall. The plan of care indicates to check the resident each hour to ensure safety. No documentation was found for the hourly check of the resident and during interviews with staff #108, #109, #113 and #114, no staff were aware of the hourly check of the resident.

A further review of the plan of care was done by the inspector and no review of the plan of care was found after the fourth fall dated on April 06 and the fifth fall dated on April 07.

The care plan further indicated that after six falls, interventions were added to place the bed at the lowest appropriate position based upon bed height and to put a fall mat beside resident bed.

During a review of the home policy titled "fall prevention, Long Term Care" number CLIN CARE 33LTC reviewed in August 2017, under Fall prevention and risk reduction that the Registered staff will conduct a post-fall huddle immediately post-fall. The policy further indicated under tab. 3.7 that the RN reviews and verifies the fall prevention interventions and ensure that the interdisciplinary care plan is updated.

During interviews on October 11, 2017, PSW #108, #113, full time PSW's who were assigned to resident #007 indicated that they do not recall any specific interventions for fall prevention in place for the resident. PSW #108 further indicated that he was assisting resident #007 for transfers but does not recall specific interventions.

During interview on October 11, 2017, RPN # 109, full time RPN who was taking care of resident #007 indicated that she does recall a time when resident #007 was falling often but does not recall specific interventions for fall prevention as the resident was not cooperative with staff members and was falling more on nights. She further indicated that when a resident fall, the nursing staff have to find the cause and what happened in order to add specific interventions for the resident. The RPN further indicated that after several falls, if the interventions are not effective, the physician will be contacted and a review of the resident's medication will be done.

During interview on October 12, 2017 with full time with RN #114 who was taking care of resident #007, she indicated that when a resident fall, a post fall huddle would be

completed as soon as possible during the shift. She further indicated that a plan of care would be implemented following the resident's admission which will identify specific interventions as per the risk of falls completed during the resident's admission. She further indicated that if recurrent falls and interventions are already in place there was not much other interventions to add other than continuing to monitor the residents. When Inspector #592 inquired about resident #007, the RN indicated that the resident was falling often and that at one point a lower bed was put in place but was not effective as the resident would not stay in bed. She further indicated that resident #007 had a hard time to mobilize with the wheelchair because of the lay out of the room, therefore the home had removed the furniture's in order for the resident to have a better access. RN #114 further indicated that there was no new interventions put in place after several falls from resident #007 until the resident was witness falling, then measures were taken to modify the environment has the staff were unable to implement any other interventions before as the resident was not witness, therefore it was hard for the staff to know which type of interventions was required to be put in place.

During a review of the resident health care records with RN #114 presence, she indicated to the Inspector that resident #007 had several falls within one month and she was unable to find any specific interventions other than the environment that was modified to accommodate the resident on a specific date. She further indicated that all the interventions such as lower bed and close monitoring were in place for the resident but that the staff was unable to prevent the falls and that there was nothing else to do other than keeping the same interventions in place and that there was nothing to do more.

A letter of response was provided by the active Administrator at that time to Inspector #592 following some concerns brought forward by the family member of resident #007 about frequent falls and staff not taking measures to prevent the resident from falling. The letter indicated that the home have responded by indicating that interventions were put in place such as reorganizing the room's environment and that several physiotherapy assessment were conducted for the resident's mobility strength and balance.

A review of the progress notes was done by the Inspector which indicated that the interventions described above were not put in place until the seventh fall incident.

As such, the plan of care for resident #007 was not reviewed and revised when the care set out in the plan was not effective. [s. 6. (11) (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 when a resident's care needs changed or when the care set out in the plan of care has not been effective, that the plan of care will be reviewed and revised, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

**Specifically failed to comply with the following:**

**s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:**
**6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).**
**2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).**
**3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).**
**4. Consent. O. Reg. 79/10, s. 110 (7).**
**5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).**
**6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).**
**7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).**
**8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's condition was reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Resident #025 was observed self-propelling on the unit in a wheelchair at various times and days during the inspection by inspector #550 with a specific physical device in place. According to interviews with staff and the documentation in the resident's health care records, the resident should has a different type of safety device in place to prevent falls and is identified as a frequent faller.

During an interview, the Director of Care indicated to the inspector that the registered staff are responsible to reassess the resident's condition and evaluate the effectiveness of the restraining at least every eight hours as per their policy and sign in the electronic "Treatment Administration Records System" (TARS) to indicate that this was done.

Inspector #550 reviewed the documentation in the TARS for resident #025's for a two weeks time frame period. The documentation indicated that the resident's condition was reassessed and the effectiveness of the restraining was evaluated at 0700hrs, 1400hrs and 2200hrs; not at least every eight hours as per the legislation.

During an interview with RN #114 on October 10, 2017, she indicated that the time for documentation of the resident's condition reassessment and effectiveness of the restraining was set at 0900hrs, 1400hrs and 2200hrs because at other times the resident is in bed and not using the restraint therefore it cannot be completed.

During an interview on October 13, 2017, and after reviewing the TARS with the inspector, the DOC indicated that the registered staff do not document the reassessments of the restraints in the TARS every eight hours. The scheduled time of 0900hrs, 1400hrs and 2100hrs that was entered in the TARS by the registered staff is the home's scheduled time for treatments that are to be administered three times per day. She indicated that the resident's condition reassessment and effectiveness of the restraining has to be done at least every eight hours at the end of each shift. She then changed the documentation time in the TARS for 0600hrs, 1400hrs and 2200hrs.

As such, the resident was not reassessed and the effectiveness of the restraining was not evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours. [s. 110. (2) 6.]

2. Resident #026 was admitted to the home in 2017 with multiple health conditions including dementia and dystonia. Inspector #550 observed the resident seated in a wheelchair with a specific physical device in place on October 10 and 17, 2017.

During interviews on October 17, 2017, RPN #123 indicated to the inspector that resident #026 required a specific physical device to be in place in his/her wheelchair to prevent falls due to agitation. PSW #124 indicated the resident is not able to remove the physical device and that it is required to prevent the resident from falling off the wheelchair as he/she moves a lot in his chair.

The Director of Care indicated to the inspector that the registered staff are responsible to reassess the resident's condition and evaluate the effectiveness of the restraining at least every eight hours as per their policy and sign the TARS to indicate that this was done.

Inspector #550 reviewed the documentation in the TARS for resident #026 from for a two week time frame period. The documentation indicated that the resident's condition was reassessed and the effectiveness of the restraining was evaluated at 0700hrs, 1400hrs and 2200hrs therefore not at least every eight hours as per the legislation.

During an interview on October 13, 2017, and after reviewing the TARS with the inspector, the DOC indicated that the registered staff do not document the reassessments of the restraints in the TARS every eight hours. The scheduled time of 0900hrs, 1400hrs and 2100hrs that was entered in the TARS by the registered staff is the home's scheduled time for treatments that are to be administered three times per day. She indicated that the resident's condition reassessment and effectiveness of the restraining has to be done at least every eight hours at the end of each shift. She indicated she would change the documentation time in the TARS for 0600hrs, 1400hrs and 2200hrs.

As such, the resident was not reassessed and the effectiveness of the restraining was not evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours. [s. 110. (2) 6.]

3. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licenses shall ensure that the following are documented:

5. The person who applied the device and the time of application
6. All assessment, reassessment and monitoring, including the resident's response

7. Every release of the device and all repositioning
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Resident #025 was observed self-propelling his/her wheelchair on the unit at various times and days during the inspection by inspector #550 with a specific physical device in place.

Resident #026 was observed by the inspector on two specified days seated in his/her wheelchair with the specific physical restraint in place.

During an interview on October 13, 2017, the Director of Care and the Administrator/Executive Director indicated to the inspector that as indicated in their policy, the PSWs are responsible for documenting the application of a restraint, all assessment, reassessment and monitoring including the resident's response, every release of the device and all repositioning, and the removal or discontinuance of the device including the time of removal or discontinuance. This documentation is done by PSWs in Point of Care (POC). The post-restraining care is done in the progress notes by the registered staff as required.

During an interview on October 17, 2017, PSW #124 indicated to the inspector that residents with restraints are verified every 1-2hrs and they are repositioned when needed depending if the resident requires one or two staff to reposition and depending on the availability of staff. She does not document the time of the application, all assessments, reassessments, monitoring, every release and repositioning and removal or discontinuance as there are no documents for this and it is not done in POC.

Inspector #550 reviewed document titled "Documentation Survey Report v2" which is the detailed documentation for restraints from POC with the Administrator/Executive Director for those two residents for a two weeks time frame period. The PSWs are to document hourly the use of the restraint and the resident's response using this legend identified on the report:

Use:
1-applied
2-removed
2-released, repositioned, and reapplied
3-released, toileted, reapplied

4-checked

Resident's response:
C-calm/comfortable
U-unsettled/uneasy
S-sleeping
O-other

It was noted by the inspector and the Administrator/Executive Director that the legend for the use of the restraint contained two #2; 2-removed and 2-released, repositioned and reapplied. There was no way to determine when the restraint was removed and when it was released, repositioned and reapplied.

It was also observe that there was no documentation for the use of the restraint and the resident's response for resident #025 on several identified dates and times.

It was also observed that there was no documentation for the use of the restraint and the resident's response for resident #026 on several identified dates and times.

The Administrator/Executive Director and the DOC indicated that the two code #2 in the legend on the report was a mistake and that they would have this corrected to have a separate code for both actions.

As evidenced, every application and time of application, all assessment, reassessment and monitoring including the resident's response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care were not always documented. [s. 110. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is restrained by a physical device, his/her condition is reassessed and the effectiveness of the restraining is evaluated by a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances and that the following is documented: the circumstances precipitating the application of the physical device, the alternatives considered and why they were inappropriate, the the person who made the order, what device was ordered and any instructions relating to the order, consent, the person who applied the deice and the time of application, all assessment, reassessment and monitoring including the resident's response, every release of the device and repositioning and the removal or the discontinuance of the device including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the restraint plan of care include an order by the physician or the registered nurse in the extended class.

On October 13, 2017, resident #025 was observed by inspector #550 wearing a specific physical device when seated in his/her wheelchair.

During an interview on that same day, RPN #109 RPN indicated to the inspector that this resident requires the physical device when the resident is in his/her wheelchair at all times to prevent the resident from falling. PSW #111 indicated that resident #025 requires the physical device when seated in his/her wheelchair as he/she would transfer himself/herself on his/her own and fall.

Inspector #550 reviewed the resident's health care records and noted documented in the progress notes that resident #025 was assessed by the occupational therapist (O.T.) #122 on a specified date. It was documented by the O.T. #122 that he had changed the resident's physical device to another type and that one of the pieces of equipment was no longer required. The inspector was not able to find an order by the physician or a registered nurse in the extended class for the other type of physical device suggested by OT #122 in the resident's health care records.

During an interview, RN #114 indicated to inspector #550 that she was not aware of the Legislation's requirement that a physical device has to be ordered by a physician or a registered nurse in the extended class. She thought that the OT could order a restraint.

The DOC and the Administrator/Executive Director indicated to inspector #550 during an interview that all restraints require an order from a physician or a nurse in the extended class as per their policy and that RN #114 should have contacted the resident's physician and obtained an order for the four point seat belt with reduced access button. [s. 31. (2) 4.]

**Issued on this 9th day of November, 2017**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | MELANIE SARRAZIN (592), JOANNE HENRIE (550) |
| **Inspection No. / No de l'inspection :** | 2017_548592_0021 |
| **Log No. / No de registre :** | 004061-17, 009996-17, 011815-17, 016390-17, 016391-17, 016396-17, 016398-17, 016399-17, 016401-17 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Nov 9, 2017 |
| **Licensee / Titulaire de permis :** | BRUYERE CONTINUING CARE INC.<br>43 BRUYERE STREET, OTTAWA, ON, K1N-5C8 |
| **LTC Home / Foyer de SLD :** | RESIDENCE SAINT- LOUIS<br>879 CHEMIN PARC HIAWATHA, OTTAWA, ON, K1C-2Z6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Melissa Donskov |

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)

**Linked to Existing Order / Lien vers ordre existant:** 2017_619550_0004, CO #001;

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The Licensee is ordered to :

1. Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment. The interventions identified in the Health Canada (HC) Guidance Document companion document, " A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment"(U.S. FDA June, 2006), shall be considered for each resident and their bed system, including those bed systems with a therapeutic air surface. This will be done using an individualized, systematic and documented approach.

2. Develop and implement a process for ensuring that all future bed system failures, are addressed immediately by taking the necessary corrective actions in accordance with the HC companion document titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment"(U.S. FDA June, 2006).

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that where bed rails are used,

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

The home was noted to be non-compliant with O.Reg s. 15. (1), where bed rails are used in the home, during the Resident Quality Inspection conducted on April 18, 2017. A compliance order was issued with a compliance date of May 30, 2017. The home was granted as per their request an extension with a new compliance date for August 31, 2017. In addition, as per their request, the home was granted a second extension with a new compliance date of October 13, 2017.

It is to be noted that the order contained five criteria for the licensee to meet.

Criteria 1a and 1b was to develop a "bed System Assessment" safety questionnaire related to bed safety hazards including 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 was required to contain questions which would be answered by the assessors related to: a. while the resident was 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.

Criteria 2 was to have an interdisciplinary team to assess all residents identified with one or more bed rails using a "Bed System Assessment" safety questionnaire and to document the results and recommendations for each resident and actions that were taken.

Criteria 3 was for the interdisciplinary team to re-assess all residents who were using 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.

Criteria 4 was that steps and/or re-taken by the home to prevent resident entrapment by taking into consideration all potential zones of entrapment when

resident beds were changed and /or if any part of the bed was modified including the side rails or/and the mattress.

Criteria 5 was to develop and implement education and information package for staff, families and residents by 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.

Criteria 1a and b, 2, 3 and 5 were met by the licensee.
Criteria 4 was not met by the licensee as per the following described below;

A follow-up inspection to the order was conducted on October 18, 2017.

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.

In an interview with the Administrator on October 18, 2017, she indicated to the Inspector that following the Resident Quality Inspection, the home has created a "Bed System Assessment" safety questionnaire related to bed safety hazards which included relevant questions and guidance related to bed safety hazards and that all the residents were assessed using a form titled "Resident and Bed System Safety Assessment located in the home's software system. The Administrator further indicated that when a new resident is admitted, a bed is provided to the resident with no rails until the resident and bed system safety assessment is completed. She further indicated that following the results of the assessment, specific alternatives and equipment required will be based on the resident's individual needs. The Administrator also indicated that additional information related to changes done to the resident's bed as well as family concerns and authorization would be found in the resident's progress notes as needed. During the interview the Administrator indicated that 198 beds were evaluated and tested for entrapment hazards zones and that some beds were discarded following the results of the test and a total of 67 beds were purchased to replace them. She further indicated that education was provided to the staff, the residents and the family members to identify the regulations and prevailing practices governing adult hospital beds, the risk of bed rail use, whether beds pass or fail entrapment zone testing.

The Home's Coordinator of Auxiliary Services provided to the Inspector a spread sheet for the tracking of the tested beds and entrapment zone testing. The

spread sheet identifies 198 beds with room numbers, resident names, bed numbers, type of beds, type of rails used, zone of entrapment (Pass or failed), type of mattress, comments, reassessment and pre-admission follow-up. The Coordinator indicated that the letter F was the coding used to indicate a fail to a specific zone of entrapment. She further indicated that if the boxes were left empty to the section of the zones area, it meant that the zone had pass.

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.

During a review of the home's tracking sheet, it was noted that 16 beds were identified with the letter F in boxes related to the assessment (Pass or Fail) of zones of entrapment.

The spread sheet indicated that:
Five beds were identified with the letter F for zone 7
Four beds were identified with the letter F for zone 6
One bed was identified with the letter F for zone 3
Nine beds were identified with the letter F for zone 2
One bed was identified with the letter F for zone 1

The spread sheet also identified that the home has eight therapeutic air surfaces in use with empty boxes under the risk of entrapment zone indicating that the zone of entrapment had pass.
As per the Health Canada guidance document, bed systems with therapeutic air surfaces are exempt from the prescribed testing for zones 2-4 due to the highly compressible nature of the mattresses.

On October 19, 2017, Inspector #592 did a review of the health care record for three residents identified with failed zone of entrapment.

Resident #028's bed was identified with failed zone 1, 2, 3 and 6.

Resident #028 was admitted in 2015 with several diagnosis such as arthritis and depressive episodes. The Resident and Bed System Safety Assessment completed on a specified date, indicated that the resident has a specified high low bed in place with four bedrails of which the resident only use one quarter rail. The Resident and Bed System questionnaire further indicated that question #2 which is to assess the level of risk for side rails and injury, was documented as a "yes" for the resident to suffer from agitation, have epilepsy or other involuntary movements, which may cause entrapment. The current plan of care indicated that the resident chooses to keep rails for own sense of security buy using one ¼ rail and leaving the other three ¼ rails down.

On October 20, 2017, Inspector #592 observed the resident #028's bed with one ¼ rail up . The rail was observed with a gap of five inches between the frame of the bed and the rail (zone 2)

Resident #027's bed was identified with failed zone 2.

Resident #027 was admitted in 2016 with several diagnosis such as diabetes mellitus and dementia. The Resident and Bed System Safety Assessment completed on a specified date, indicated that the resident has a specified high low bed in place with two quarter side rails at the head of the bed to assist resident. The Resident and Bed System questionnaire further indicated that question #2 which is to assess the level of risk for side rails and injury, was documented as a "yes" for the resident to suffer from agitation, have epilepsy or other involuntary movements, which may cause entrapment. The Resident and Bed System questionnaire further indicated that question #2 under bed system and sleep evaluation, that the resident suffers from a sleep disturbance. The current plan of care indicated that the resident has two full bed rails to assist with mobility and safety, requested by the resident and the Substitute Decision Maker (SDM).

Resident #029's bed was identified with failed zone 2.

Resident #029 was admitted in 2012 with several diagnosis such as fibromyalgia and osteoporosis. The Resident and Bed System Safety Assessment completed on a specified date indicated that the resident has a specified high low bed in place with one full side rail. The Resident and Bed System Safety Assessment further indicated that the resident was made aware of the entrapment risk with the one full side rail following the results of the bed assessment but the resident still expressed to keep the full rail in place.

Upon a review of the current plan of care for the three residents above, no interventions, steps and actions were found to prevent resident's entrapment to the identified zones.

On October 20, 2017, in a discussion with the Administrator she indicated that she was made aware of the results of the bed system evaluation and the beds flagged with failed zones of entrapment. The Administrator further indicated that there was no formal process in place to prevent resident's entrapment with regards to the beds identified with failed zones of entrapment. She further indicated that the home has retested the beds identified with failed zones and was able to do some modifications as well has having discussion with the residents and the family members exposing the risk of entrapment by keeping the rails and that a result of the discussion was kept in the resident health care records. At the time of the inspection, the home was actively working to put steps in place to prevent resident's entrapment. [s. 15. (1) (b)] (592)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 15, 2017

**Order # / Ordre no :** 002

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

**Linked to Existing Order / Lien vers ordre existant:** 2017_618211_0008, CO #002;

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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).

**Order / Ordre :**

1.The licensee is ordered to implement a monitoring process to ensure that all dietary aids serving meals on the units are informed of the planned menu for the meal they are going to serve and that the food carts contain all food items as per the planned menu before being brought to each units.

2.This process shall ensure that the menu items are offered to residents at meal time in accordance with the planned menu.

3.This monitoring process is to be documented.

**Grounds / Motifs :**

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

This inspection is a follow-up inspection for CO #002, issued on June 28, 2017 with a compliance date of September 28, 2017.

On October 5, 2017, Inspector #550 observed the lunch meal service in a specified unit dining room at 1200hrs. The menu choices for desert according to the week 3 therapeutic diets, Spring-Summer menu day 18 which was posted in the hallway at the dining room entrance were:
Date squares for regular and soft textured diets and ice cream for mince and puree textured diets
Diced peaches for regular and soft textured diets and pureed peaches for the puree and mince textured diets.

The residents were offered date squares, diced peaches, yogurt and red Jello as per items available on the desert cart. Inspector #550 noted that the ice cream for mince and puree textured diets was not offered to any of the residents. Dietary Aid #110 indicated to the inspector that the ice cream was not put on the desert cart as this item requires to be frozen. It was available in the refrigerator in the servery and PSWs had to get it from the freezer. PSW #111 indicated that she was not aware that ice cream was on the menu for that meal.

On October 6, 2017, inspector observed the breakfast and lunch meal services on another unit.
The breakfast and lunch menu posted in the dining room indicated:

Breakfast:
Banana
Prunes/puree
Cream of wheat
Cold cereals
Various toasts
Scrambled eggs

Lunch:
Pea soup/pureed celery soup
Tomatoes and cucumbers with vinaigrette/Pureed green salad
Assorted sandwiches (egg/ham)/Pureed veal
Breaded lemon pepper fish/mashed fish without the breading/pureed fish
Carrots/chopped carrots/pureed carrots
Mashed potatoes
Sweet potatoes fries
Strawberry shortcake
Pureed strawberries
Bananas/individual pureed fruits

Resident #010 was served a plate with scrambled eggs, two cut up toasts and sliced bananas after he/she ate his/her cereal at breakfast. Other food choices were not offered. At lunchtime, the resident was served a plate with 3 pieces of sandwiches, mashed potatoes with gravy and carrots, food choices were not offered. Inspector reviewed the resident's kardex at point of service and it did not indicate that this resident was not to be offered food choices.

Resident #011 was fed hot cereals, pureed bread and pureed eggs for breakfast. The resident was not offered or provided with bananas or prunes as per the planned menu. Inspector reviewed the resident's kardex and it did not indicate that the resident was not to be provided with fruits at breakfast.

Resident #012 was given a plate containing eggs and cut up toast with jam for breakfast. The resident was not provided with or offered cereal or fruit as per the planned menu. The inspector reviewed the resident's kardex which did not indicate that the resident is not to be given any cereal or fruit at breakfast or that this resident was not able to make food choices.

Resident #013 was fed cream of wheat, pureed bread and pureed eggs for breakfast. The resident was not provided with fruits as per the planned menu. The inspector reviewed the resident's kardex which did not indicate that the resident was not to be given fruit at breakfast.

PSW #102 attempted to feed hot cereals in a glass with a straw to resident #014 at breakfast which the resident refused. RPN #109 then gave PSW #102 a glass with a straw which she later indicated to inspector contained a food supplement mixed with milk. The resident consumed all of the milk with the food supplement. The resident was not offered or provided with other food items on the menu after he/she refused to eat the cereal. RPN #109 indicated to the inspector that this resident often does not eat and thus the reason for giving the food supplement. She further stated that when the resident refuses to eat his/her cereals, he/she always refuses everything else therefore there is no use offering him/her the other food items and that the resident has always been this way. Inspector reviewed the resident's kardex and it did not indicate that the resident was not to be offered other food items when the resident does not eat or that the resident was not able to make food choices.

At 0925hrs, resident #015 arrived in the dining room for breakfast and resident #016 who had previously refused to eat had decided he/she was ready to eat. By this time the food cart containing the hot food items had already left the unit and there was no hot food items to offer the two residents. PSW #111 gave both residents cold cereal with milk and informed the inspector that she was going to make them toasts in the servery. She stated that she was not able to offer the eggs and hot cereals as the hot food cart was already gone.

Resident #008, #009 were not offered or provided with pureed green salad at

lunchtime as per their therapeutic diet as there was none left. Inspector #550 observed that none of the residents in the dining room were offered bananas, which was one of the food items' identified on the menu for the dessert at lunchtime. PSW #111 and RPN #109 indicated to the inspector that they were not aware that bananas were on the menu for desert as they had not looked at the menu, furthermore indicating that there were no bananas available on the desert cart. The RD who was in the dining room at the time, showed the employees that the bananas were on the top of the cart used to transport the desert from the kitchen to the servery which was located in the servery. This cart is where PSWs get the plated desert to put out on the desert cart and offer to residents.

On October 10, 2017, inspector #550 observed the breakfast meal service on another unit.
The posted menu for breakfast:
Mandarin, pureed prune
Oatmeal
Cold cereals
Toasts
Scrambled eggs

Resident #017 was served a plate containing toasts with peanut butter and scrambled eggs by D.A. #110. The resident was not offered food choices, cereal and fruit.
Resident #018 was served coffee and toast by D.A. #110. The resident was not offered food choices, fruit, cereal or eggs.
Resident #019 was served toast, hot cereal and cranberry juice. The resident was not offered food choices, fruits or eggs.
Resident #020 was served cranberry juice, bran flakes in milk, toast and eggs. The resident was not offered food choices or fruits.

These four residents were not offered food choices as per the planned menu. Inspector reviewed the kardex at point of service for all four residents and it did not indicate that these residents were not to be offered the planned menu items or that these residents were not able to make food choices.

At 0920hrs, Inspector observed that the residents were not offered any fruit as per the menu excepted for three residents who were served prunes. During an interview, D.A. #110 indicated to the inspector that the menu indicated

mandarins but that he did not have any that morning as the order had not been placed last Thursday. Because of the long weekend, the mandarins were not delivered to the home. He explained that he only had three servings of prunes as only the same three residents take prunes every morning. Inspector asked if the pureed prunes were available as per the menu for the residents. The D.A. further indicated that the residents in the small dining room do not need to take prunes as they have no problems with their bowel movements. At 0945hrs, the FSM #121 brought mandarins to the unit. At this time, there were only 5 residents left in the dining room eating breakfast, all the others had finished their breakfast and returned to their room. She indicated to the inspector she had been made aware by the Administrator/Executive Director that mandarins were not available on the unit although they were on the menu. The mandarins were available and should have been brought to the unit by the D.A. #110 at the same time he brought his food cart. She further explained that even though prunes were on the daily breakfast menu, they are not provided to all residents on a daily basis; there are only three specific residents to which prunes are given daily. Prunes are provided to the other residents according to a schedule she has in her office.

At 0955hrs, resident #021 was brought by staff for breakfast and was served a regular yogurt, mandarins, eggs and toasts. The resident was not offered cereals as per the planned menu. D.A. #110 indicated to the inspector that this resident never takes cereal therefore it is not offered. Inspector reviewed the resident's kardex and it did not indicated that cereal are not to be offered to this resident or that the resident cannot make food choices.

During an interview on October 26, 2017, D.A. #110 indicated to the inspector that residents who cannot make food choices are served as per their likes and dislikes documented in their kardex at point of service and that he knows what the residents prefer to eat as he has worked there for many years. Resident #017 does not take any cereal in the morning, resident #018 is provided with cereal, fruit and eggs only if there is a staff member available to feed him/her these items, resident #019 does not like mandarins and eggs and resident #020 does not eat fruits in the morning.

During an interview on October 10, 2017 with the Registered Dietician, the two Food Service Managers, the Director of Care and the Executive Director they indicated to the inspector that all the food items on the planned menu are to be offered to all residents including modified texture diets.

As evidenced above, the planned menu items were not offered and available to each resident at each meal and snack.

Non compliance was previously issued as a compliance order (CO) on June 28, 2017, with a compliance date of September 28, 2017 under inspection #2017_618211_0008. A voluntary plan of correction (VPC) was issued on February 22, 2017, under inspection #2017_619550_0003. A voluntary plan of correction (VPC) was issued on February 16, 2017, under inspection #2017_619550_0004. A voluntary plan of correction (VPC) was issued on July 29, 2016, under inspection #2016_289550_0023. A voluntary plan of correction (VPC) was issued on January 21, 2016, under inspection #2015_289550_0027. [s. 71. (4)] (550)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 15, 2017

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

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

**Issued on this 9th day of November, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Name of Inspector / Nom de l'inspecteur :** Melanie Sarrazin

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