Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 8, 2016	2016_288549_0003	034235-15	Complaint

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 OVERLEA BLVD. TORONTO ON M4H 1P4

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

THE SALVATION ARMY OTTAWA GRACE MANOR
1156 WELLINGTON STREET OTTAWA ON K1Y 2Z3

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

RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 11, 12, 13, 18, 2016

This Complaint Inspection is related to a complaint regarding the plan of care.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses, (RN), the home's Behavioural Support Outreach worker, the RAI Coordinator, the Assistant Director of Care (DOC) and the Executive Director.

The inspector toured the home, reviewed resident health care records, the home's Advance Directives form, the Advanced Directives policy #C14, revised May 2015, the Care Plan and Plan of Care policy #G6 ,revised November 2015 and the home's investigation documentation.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #001 was admitted to the home on a specific date in January 2011 with multiple diagnoses.

The resident was transferred to a specific unit in the home on a specific date in October 2015.

Resident #001 was admitted to the hospital on a specific date in July 2015 from the Long Term Care home. The Discharge Notes dated on a specific date in July 2015, indicated the hospitalization was due to a specific medical condition. While in hospital the resident was assessed for a specific surgical procedure. In discussion with the resident's spouse who is the Substitute Decision Maker (SDM)) it was decided not to proceed with any surgical or procedural intervention. The specific surgical procedure was not done and the resident was to receive comfort care only. The discharge note also indicates that there were long conversations held between the hospital physician and family and they were very clear that the resident should have a Do Not Resuscitate status with Level 3 care preferences.

Resident #001 returned to the Long Term Care home on a specific July 2015. Progress notes dated on a specific date in July 2015 indicated that RPN #101 discussed the end of life preferences with the resident's SDM. The resident's end-of-life care preference prior to return from hospital was a Level 4 which the home defines as: transfer to acute hospital initiating Cardio Pulmonary Resuscitation (CPR).

Progress notes dated on a specific date on August 2015 signed by the attending physician indicated that he met at length with the family of resident #001 to review the resident's end-of-life care preferences.

Resident #001 is moderately cognitively impaired as indicated in the Minimum Data Set dated on a specific date in August 2015.

The SDM made the decision after the discussion with family, RPN #101 and the attending physician to change the resident's end of life care preferences for resident #001 to Level 3 on a specific date in August 2015. The home defines Level 3 as: Transfer to Acute Care hospital without initiating Cardiac Pulmonary Resuscitation (CPR). The SDM requested additional preferences as part of resident #001's end-of-life preferences.

Inspector #549 reviewed resident #001's progress notes dated a on a specific date in August 2015 signed by RPN #113 which indicate that the SDM signed the end of life form at Level 3 with some exclusion. The progress notes also provide a detail description of the SDM's end of life instructions..

Inspector #549 reviewed resident #001's health care record and was able to locate the Ministry of Health and Long Term Care-Do Not Resuscitate Confirmation Form signed by the SDM, the attending physician and RPN #113 dated on a specific date in August 2015, which indicated to the Paramedics and Firefighters "Do Not Resuscitate".

Resident #001 is moderately cognitively impaired as indicated in the Minimum Data Set dated on a specific date in October 2015.

Inspector #549 reviewed the GPO notes dated on a specific date in September 2015 which indicated that the resident's dementia was evident with poor insight and judgement. The progress notes dated an a specific date in October 2015 signed by the physician indicated that the resident's spouse who is the SDM for Resident #001 was contacted by phone and clearly understands that the resident's condition is "end-of-life"

and the SDM would like the resident to be comfortable.

Inspector #549 reviewed resident #001's progress notes dated on a specific date in December 2015 which indicated that resident #001 had fallen forward out of the shower chair in the tub room. The progress notes indicated that the resident was non-responsive, not breathing and had no pulse. Charge RN #110 initiated CPR as Charge RN#110, RPN#103 and RPN #101 did not know that Resident #001 had a Do Not Resuscitate order. The Emergency Report dated on a specific date in December 2015 indicated a questionable cardiac event.

Inspector #549 reviewed the home's Care Plan and Plan of Care Policy #G6 revision November 2015 indicated in the Application of Policy bullet number 2 the following: A comprehensive Care Plan is completed within 7 days of admission, including: a) a medical history and treatment plan, b) resident-specific goals and interventions, c) target dates and identification of team members assigned. Bullet 5 states the Care Plans are updated at least quarterly, upon readmission of the resident from hospital and when a significant change in status or treatment regime has occurred.

Inspector #549 reviewed the home's Advanced Directives Policy #C14 revision May 2015 indicated in the definition section the following: Treatment. For the purpose of this practice document, treatment relates to options a resident may have available at or near end of life. The Health care consent Act, 1996 defines treatment as any act that is performed for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose, and includes a course or plan of treatment. Resuscitation is categorized as a treatment under this act. The policy also states that end of life care also includes aspects that are beyond the scope of palliative care, such as advance care planning.

Resident #001's SDM made the decision in consultation with the home to provide end of life care to the resident at a Level 3 which did not include CPR however, RN #110 initiated CPR when the resident was found unresponsive, not breathing and had no pulse.

On January 12, 2015 the ADOC confirmed that the plan of care for resident #001 did not provide clear direction to staff and others who provide direct care to the resident related to the resident's end of life care preferences.

The Executive Director and ADOC indicated on January 18, 2016 that the home's expectation is that the resident's requested end-of-life care preferences be documented

in the written plan of care.

The issue of the residents who have chosen to sign an end-of-life care preference not being documented in the resident's care plan is wide spread throughout the home this poses a potential of actual harm to the residents.

During an interview with the ADOC, RN#105, RN#110 and RPN #103 on January 11, 2016, it was indicated to Inspector #549 that there is no process in place to identify residents who have chosen to make their end-of-life care preferences communicated to the home other than in the resident's health care record at the nursing station.
[s. 6. (1) (c)]

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

On a specific date in December 2015 resident #001 was given a shower by PSW #104. Resident #001 was sitting in the shower chair with the seat belt off. When PSW #104 turned to get a dry towel the resident fell forward to the floor. Resident #001 sustained a laceration and a fracture.

Resident #001 was admitted to the home on a specific date in January 2011 with multiple diagnoses.

The Minimum Data Set dated a specific date in October 2015 indicates that the resident's cognitive skill for daily decision-making is moderately impaired.

Resident #001 resided on the Wellington House unit a period of time then transferred to Gladstone House unit.

Resident #001 was admitted to the hospital on a specific date in July 2015 due to cardiac issues. The resident returned to the Long Term Care home on a specific date in July 2015. Progress notes dated on a specific date in July 2015 indicated that the Power of Care (POC) informed the nursing staff that resident #001 care needs changed and the resident requires a tempo lift for transfer and total care for feeding.

During an interview full time PSW #100 indicated that he provided care to resident #001 when the resident lived on Wellington House unit. PSW #100 indicated that the resident's bathing care needs changed after the resident returned from the hospital in July, 2015.

PSW #100 indicated that the resident was given a bath one day a week and a shower one day a week previous to his/her hospital admission in July 2015. Once the resident returned from the hospital bathing care needs where changed to a tub bath one day a week then a bed bath one day a week.

PSW # 100 indicated that resident #001 was leaning forward and assessed by the unit RPN that a shower was no longer appropriate. PSW #100 indicated that while the resident was on the Wellington House unit he/she received a tub bath or a bed bath after a specific date in August 2015 when the resident care needs changed.

On January 13, 2016, during an interview RPN #106 indicated that she recalls having a conversation with the resident's POC a few days after the resident returned from hospital in July 2015. The conversation RPN #106 recalls was to let the POC know that resident #001 would no longer be having a shower but a total bed bath on a specific evening shift.

RPN #106 indicated the bathing change was due to the resident leaning forward and a shower would not be appropriate, the POC agreed to the bathing change.

RPN #106 confirmed with Inspector #549 that the written plan of care for resident #001 was not revised to indicate that resident #001 was to have a tub bath on a specific day shift and a total bed bath on a specific evening shift.

A review of the flow sheets by Inspector #549 indicate that the resident received a tub bath or bed bath starting on a specific date in August 2015 with the exception of a shower on a specific date in September 2015 until his/her transfer to the Gladstone House unit.

Resident #001 was transferred to the Gladstone House unit on a specific date in October 2015.

Inspector #549 reviewed the resident's flow sheets for the specific time period in 2015:; there is no entry indicating a shower or a bath for specific date during the specific time period. The entry for a specific date in same time period indicates a bed bath; another specific date in specific time period indicates a tub bath; another specific date in the specific time period indicates a shower and another specific date in the specific time period indicates a shower.

During an interview on January 12, 2016, PSW #104 indicated to the inspector that on a specific date in December 2015, she asked RPN #103 if resident #001 was to be given a tub bath or a bed bath as it was his/her regular bath day. PSW #104 indicated that RPN #103 told her that the resident no longer receives a bed bath that he/she is to have a shower.

During an interview on January 12, 2016 with RPN #103 it was indicated to the inspector that resident #001 was given a shower as per the current the plan of care. RPN #103 indicated to the inspector that she was not aware that the resident was not to have a shower due to his/her lack of ability to maintain a sitting position. The RPN also indicated she was not aware that the resident received a tub bath or bed bath prior to being transferred to Gladstone House unit due to the resident's inability to maintain a sitting position.

During an interview with Gladstone House unit PSW #109 on January 13, 2016, it was indicated to the inspector that resident #001 was given a tub bath on a specific day shift and a shower on a specific evening shift. PSW #109 indicated that she has provided resident #001 with a shower when the resident was assigned to her.

Inspector #549 reviewed the written plan of care dated a specific date in October 2015; last revision on a specific date in November 2015, which was the written plan of care in place on a specific date in December 2015. The written plan of care indicated that resident #001 was to receive a bath on a specific day shift and a shower on a specific evening shift.

Progress notes dated a specific date in August 2015 indicate that the physiotherapist completed a re-assessment due to a significant change. The POC informed the physiotherapist that the resident was not comfortable in his/her current wheelchair. The Physiotherapist was able to find a donated tilt wheelchair for a trial.

During an interview on January 13, 2016 PSW #100 indicated that the resident was positioned in a tilt position all the time except for meals since a specific date in August 2015.

During an interview with PSW #109 it was indicated to the inspector that when resident #001 was transferred to the Gladstone House unit the resident was in a tilt wheelchair which was to be tilted at all times except for meals.

The written plan of care dated a specific date in October 2015; last revision on a specific date in November 2015 indicates that the resident is dependent in a wheelchair with seat belt and requires one person to push wheelchair to areas on and off the unit. There is no entry indicating the resident is in a tilt wheelchair and is required to be in the tilt position all the time except for meals.

During an interview with the ADOC on January 13, 2016 it was confirmed with Inspector #549 that the written plan of care was not revised when resident #001's care needs changed related to bathing and requiring a tilt wheelchair and the position of the tilt wheelchair.
[s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 9th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RENA BOWEN (549)
Inspection No. / No de l'inspection :	2016_288549_0003
Log No. / Registre no:	034235-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 8, 2016
Licensee / Titulaire de permis :	The Governing Council of the Salvation Army in Canada 2 OVERLEA BLVD., TORONTO, ON, M4H-1P4
LTC Home / Foyer de SLD :	THE SALVATION ARMY OTTAWA GRACE MANOR 1156 WELLINGTON STREET, OTTAWA, ON, K1Y-2Z3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Roy Snow

To The Governing Council of the Salvation Army in Canada, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

In order to ensure there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident related to those residents or Substitute Decision Makers who have knowledge and who have chosen end of life care preferences the home shall:

1. Identify residents or Substitute Decision Maker who has knowledge of the resident's end of life care preferences and have provided the home with documentation related to the resident's end of life care preferences. Ensure the identified residents end of life care preferences are documented in the resident's written plan of care.

2. Ensure that when a resident or Substitute Decision Maker who has knowledge of the residents end of life preferences, make a change to the end of life care preferences that the change is updated in the resident's written plan of care.

3. Ensure the residents or Substitute Decision Maker who has knowledge of the resident's end of life preferences and have documented the resident's end of life care preferences to the home are clearly identifiable by the Registered Nursing Staff.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #001 was admitted to the home on a specific date in January 2011 with multiple diagnoses.

The resident was transferred to a specific unit in the home on a specific date in October 2015.

Resident #001 was admitted to the hospital on a specific date in July 2015 from the Long Term Care home. The Discharge Notes dated on a specific date in July 2015, indicated hospitalization due to a specific medical condition. While in hospital the resident was assessed for a specific surgical procedure. In discussion with the resident's spouse who is the Substitute Decision Maker (SDM)) it was decided not to proceed with any surgical or procedural intervention. The specific surgical procedure was not done and the resident was to receive comfort care only. The discharge note also indicates that there were long conversations held between the hospital physician and family and they were very clear that the resident should have a Do Not Resuscitate status with Level 3 care preferences.

Resident #001 returned to the Long Term Care home on a specific July 2015. Progress notes dated on a specific date in July 2015 indicated that RPN #101 discussed the end of life preferences with the resident's SDM. The resident's end-of-life care preference prior to return from hospital was a Level 4 which the home defines as: transfer to acute hospital initiating Cardio Pulmonary Resuscitation (CPR).

Progress notes dated on a specific date on August 2015 signed by the attending physician indicated that he met at length with the family of resident #001 to review the resident's end-of-life care preferences.

Resident #001 is moderately cognitively impaired as indicated in the Minimum Data Set dated on a specific date in August 2015.

The SDM made the decision after the discussion with family, RPN #101 and the attending physician to change the resident's end of life care preferences for resident #001 to Level 3 on a specific date in August 2015. The home defines Level 3 as: Transfer to Acute Care hospital without initiating Cardiac Pulmonary Resuscitation (CPR). The SDM requested additional preferences as part of resident #001's end-of-life preferences.

Inspector #549 reviewed resident #001's progress notes dated a on a specific date in August 2015 signed by RPN #113 which indicate that the SDM signed the end of life form at Level 3 with some exclusion. The progress notes also provide a detail description of the SDM's end of life instructions..

Inspector #549 reviewed resident #001's health care record and was able to locate the Ministry of Health and Long Term Care-Do Not Resuscitate Confirmation Form signed by the SDM, the attending physician and RPN #113 dated on a specific date in August 2015, which indicated to the Paramedics and Firefighters "Do Not Resuscitate".

Resident #001 is moderately cognitively impaired as indicated in the Minimum Data Set dated on a specific date in October 2015.

Inspector #549 reviewed the GPO notes dated on a specific date in September 2015 which indicated that the resident's dementia was evident with poor insight and judgement. The progress notes dated an a specific date in October 2015 signed by the physician indicated that the resident's spouse who is the SDM for Resident #001 was contacted by phone and clearly understands that the resident's condition is "end-of-life" and the SDM would like the resident to be comfortable.

Inspector #549 reviewed resident #001's progress notes dated on a specific date in December 2015 which indicated that resident #001 had fallen forward out of the shower chair in the tub room. The progress notes indicated that the resident was non-responsive, not breathing and had no pulse. Charge RN #110 initiated CPR as Charge RN#110, RPN#103 and RPN #101 did not know that Resident #001 had a Do Not Resuscitate order. The Emergency Report dated on a specific date in December 2015 indicated a questionable cardiac event.

Inspector #549 reviewed the home's Care Plan and Plan of Care Policy #G6 revision November 2015 indicated in the Application of Policy bullet number 2 the following: A comprehensive Care Plan is completed within 7 days of admission, including: a) a medical history and treatment plan, b) resident-specific goals and interventions, c) target dates and identification of team members assigned. Bullet 5 states the Care Plans are updated at least quarterly, upon readmission of the resident from hospital and when a significant change in status or treatment regime has occurred.

Inspector #549 reviewed the home's Advanced Directives Policy #C14 revision May 2015 indicated in the definition section the following: Treatment. For the purpose of this practice document, treatment relates to options a resident may have available at or near end of life. The Health care consent Act, 1996 defines treatment as any act that is performed for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose, and includes a course or plan of treatment. Resuscitation is categorized as a treatment under this act. The policy also states that end of life care also includes aspects that are beyond the scope of palliative care, such as advance care planning.

Resident #001's SDM made the decision in consultation with the home to provide end of life care to the resident at a Level 3 which did not include CPR however, RN #110 initiated CPR when the resident was found unresponsive, not breathing and had no pulse.

On January 12, 2015 the ADOC confirmed that the plan of care for resident #001 did not provide clear direction to staff and others who provide direct care to the resident related to the resident's end of life care preferences.

The Executive Director and ADOC indicated on January 18, 2016 that the home's expectation is that the resident's requested end-of-life care preferences be documented in the written plan of care.

The issue of the residents who have chosen to sign an end-of-life care preference not being documented in the resident's care plan is wide spread throughout the home this poses a potential of actual harm to the residents.

During an interview with the ADOC, RN#105, RN#110 and RPN #103 on January 11, 2016, it was indicated to Inspector #549 that there is no process in place to identify residents who have chosen to make their end-of-life care preferences communicated to the home other than in the resident's health care record at the nursing station.
(549)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

In order to ensure that the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary the home shall:

1. Identify and revise the plan of care for all residents who have changes in their bathing care needs and seating position.

2. Ensure all resident's bathing care needs and seating position changes are communicated to direct care staff to ensure the safety of the resident at all times.

3. Monitor/audit the resident's bathing care need and seating position changes to ensure that the plan of care is revised to reflect the health care and status of the resident. The home is to maintain the records of the monitoring/audits

Grounds / Motifs :

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

On a specific date in December 2015 resident #001 was given a shower by PSW #104. Resident #001 was sitting in the shower chair with the seat belt off.

When PSW #104 turned to get a dry towel the resident fell forward to the floor. Resident #001 sustained a laceration and a fracture.

Resident #001 was admitted to the home on a specific date in January 2011with multiple diagnoses. The Minimum Data Set dated a specific date in October 2015 indicates that the resident's cognitive skill for daily decision-making is moderately impaired.

Resident #001 resided on the Wellington House unit a period of time then transferred to Gladstone House unit.

Resident #001 was admitted to the hospital on a specific date in July 2015 due to cardiac issues. The resident returned to the Long Term Care home on a specific date in July 2015. Progress notes dated on a specific date in July 2015 indicated that the Power of Care (POC) informed the nursing staff that resident #001 care needs changed and the resident requires a tempo lift for transfer and total care for feeding.

During an interview full time PSW #100 indicated that he provided care to resident #001 when the resident lived on Wellington House unit. PSW #100 indicated that the resident's bathing care needs changed after the resident returned from the hospital in July, 2015. PSW #100 indicated that the resident was given a bath one day a week and a shower one day a week previous to his/her hospital admission in July 2015. Once the resident returned from the hospital bathing care needs where changed to a tub bath one day a week then a bed bath one day a week.

PSW # 100 indicated that resident #001 was leaning forward and assessed by the unit RPN that a shower was no longer appropriate. PSW #100 indicated that while the resident was on the Wellington House unit he/she received a tub bath or a bed bath after a specific date in August 2015 when the resident care needs changed.

On January 13, 2016, during an interview RPN #106 indicated that she recalls having a conversation with the resident's POC a few days after the resident returned from hospital in July 2015. The conversation RPN #106 recalls was to let the POC know that resident #001 would no longer be having a shower but a total bed bath on a specific evening shift.

RPN #106 indicated the bathing change was due to the resident leaning forward and a shower would not be appropriate, the POC agreed to the bathing change.

RPN #106 confirmed with Inspector #549 that the written plan of care for resident #001 was not revised to indicate that resident #001 was to have a tub bath on a specific day shift and a total bed bath on a specific evening shift.

A review of the flow sheets by Inspector #549 indicate that the resident received a tub bath or bed bath starting on a specific date in August 2015 with the exception of a shower on a specific date in September 2015 until his/her transfer to the Gladstone House unit.

Resident #001 was transferred to the Gladstone House unit on a specific date in October 2015.

Inspector #549 reviewed the resident's flow sheets for the specific time period in 2015:; there is no entry indicating a shower or a bath for specific date during the specific time period. The entry for a specific date in same time period indicates a bed bath; another specific date in specific time period indicates a tub bath; another specific date in the specific time period indicates a shower and another specific date in the specific time period indicates a shower.

During an interview on January 12, 2016, PSW #104 indicated to the inspector that on a specific date in December 2015, she asked RPN #103 if resident #001 was to be given a tub bath or a bed bath as it was his/her regular bath day. PSW #104 indicated that RPN #103 told her that the resident no longer receives a bed bath that he/she is to have a shower.

During an interview on January 12, 2016 with RPN #103 it was indicated to the inspector that resident #001 was given a shower as per the current the plan of care. RPN #103 indicated to the inspector that she was not aware that the resident was not to have a shower due to his/her lack of ability to maintain a sitting position. The RPN also indicated she was not aware that the resident received a tub bath or bed bath prior to being transferred to Gladstone House unit due to the resident's inability to maintain a sitting position.

During an interview with Gladstone House unit PSW #109 on January 13, 2016, it was indicated to the inspector that resident #001 was given a tub bath on a

specific day shift and a shower on a specific evening shift. PSW #109 indicated that she has provided resident #001 with a shower when the resident was assigned to her.

Inspector #549 reviewed the written plan of care dated a specific date in October 2015; last revision on a specific date in November 2015, which was the written plan of care in place on a specific date in December 2015. The written plan of care indicated that resident #001 was to receive a bath on specific day shift and a shower on specific evening shift.

Progress notes dated a specific date in August 2015 indicate that the physiotherapist completed a re-assessment due to a significant change. The POC informed the physiotherapist that the resident was not comfortable in his/her current wheelchair. The Physiotherapist was able to find a donated tilt wheelchair for a trial.

During an interview on January 13, 2016 PSW #100 indicated that the resident was positioned in a tilt position all the time except for meals since a specific date in August 2015.

During an interview with PSW #109 it was indicated to the inspector that when resident #001 was transferred to the Gladstone House unit the resident was in a tilt wheelchair which was to be tilted at all times except for meals.

The written plan of care dated a specific date in October 2015; last revision on a specific date in November 2015 indicates that the resident is dependent in a wheelchair with seat belt and requires one person to push wheelchair to areas on and off the unit. There is no entry indicating the resident is in a tilt wheelchair and is required to be in the tilt position all the time except for meals.

During an interview with the ADOC on January 13, 2016 it was confirmed with Inspector #549 that the written plan of care was not revised when resident #001's care needs changed related to bathing and requiring a tilt wheelchair and the position of the tilt wheelchair.
(549)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 8th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Rena Bowen

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