Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 30, 2017;	2017_593573_0013 (A1)	008230-17	Resident Quality Inspection

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

ANANDRAJ NATARAJAN (573) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension to the compliance date for the Compliance Order no: 001 issued as a result of the Resident Quality Inspection conducted in May/June 2017. The compliance date for the Order #001 was originally on September 22, 2017 and that will be amended to reflect a new compliance date of November 22, 2017.

Issued on this 30 day of August 2017 (A1)

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

Original report signed by the inspector.

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

ANANDRAJ NATARAJAN (573) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 24, 25, 26, 29, 30, 31, June 01, 02, 05, 06, 07, 08 and 09, 2017.

The following Complaint and Critical Incident inspections were conducted concurrently during this Resident Quality Inspection: Complaints Logs #030658-16, 034496-16 and 009972-17, related to resident care and services. Log #028820-16, a complaint related to an alleged incident of resident neglect. Logs #033822-16 and 007306-17, related to alleged incidents of staff to resident abuse.

Critical Incident Logs #030138-16, 031143-16 and 034314-16, related to alleged incidents of resident to resident physical abuse. Logs #028789-16, 031255-16 and 005386-17, related to incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. Logs #031783-16 and 031786-16, related to alleged incidents of staff to resident abuse. Log #030655-16, related to missing resident lesser than three hours.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Director of Employee Relations, Director of Spiritual Care, Placement Coordinator, Director of Food Services, Dietitian, PSW Supervisors, the Scheduler, Behavioural Support Ontario (BSO) champion staff, Maintenance Worker, Housekeeping Aide, Activity staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Chair of Family Council, President of Residents' Council, family members and residents.

During the course of the inspection, the inspector(s) toured residential and non-residential areas of the home, observed medication administration passes, recreation activities, exercise therapy classes, meal and snack services, reviewed residents health care records, the Licensee's relevant policies and procedures, minutes for Residents' Council and Family Council, home’s staffing schedules and plan, equipment cleaning schedules and maintenance schedules. In addition Inspectors observed the provision of care and services to the residents, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

- **14 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with section 15.(1)(a)(b) of the regulation in that the licensee failed to ensure that when bed rails are used 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 and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On August 21, 2012, a memo 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 titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the memo, it is written that this Health Canada Guidance Document is expected to be used "as a best practice document". The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zone 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zone1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

The Health Canada 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 Health Canada 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" (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment for residents 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, but not limited to, the resident's right to participate in the care planning process, the resident's medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. 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 health care 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.

On May 24, 2017, Inspector #592 and Inspector #573 observed that resident #029's bed had one ¾ rail that was elevated from the head of the bed. Inspectors observed a significant gap between the bed mattress and the bed rail (Zone 2). When Inspector #573 further inspected the rail, it was observed that the bed rail further expanded outward leaving a wider gap between the bed mattress and the rail of more than six inches with compression of the mattress.

Inspector #592 brought forward her observation to the Executive Director due to potential safety risk. The Executive Director accompanied Inspector #592 to resident's #029's room. When the rail was showed to the Executive Director, he indicated that the gap between the bed mattress and the rail was a risk of entrapment for the resident therefore, he indicated that the bed would be changed immediately to ensure the resident's safety.

The Inspector reviewed resident #029's plan of care in place (as defined by the home) that indicated the resident requires full bed rails and staff to observe the resident every hour while in the bed and document.

On May 25, 2017, Inspector #592 observed that resident #040's bed had one ¾ rail that was elevated from the head of the bed. A gap of approximately four inches was observed between the bed mattress and the rail. When Inspector #593 inspected the bed rail, the rail further expanded outward leaving a wider gap between the bed mattress and the rail of more than five inches with compression of the mattress.

On May 25, 2017, Inspector #592 observed that resident #036's bed had one ¾ rail elevated from the head of the bed. A gap of approximately four inches was observed between the bed mattress and the rail.

On May 26, 2017, in an interview with the DOC regarding the assessment process for residents using bed rails. During the conversation, it was determined by the DOC that there was no formal assessment process for residents using bed rails. The DOC also indicated when asked about the bed system evaluation that the maintenance staff #102 was the person responsible, therefore she did not have any documentation on bed system evaluation. The DOC further explained that in some cases, there has been discussion between the registered staff, residents and family members about the resident's need for a bed rail. As per the FDA clinical guidance document, residents are to be assessed to determine the risk of using bed rails.

On May 26, 2017, in an interview with the maintenance staff #102, who indicated that he was the person in charge of the beds where bed rails were used for conducting the bed system evaluation. He further indicated that the home does not have the tool to perform the evaluations on site but used a tool from an outside provider to conduct the bed system evaluations at that time. The maintenance staff #102 indicated that the bed system evaluations were conducted approximately one year to one and a half years ago and that several beds were flagged with failed zones of entrapment, specifically zone 2, 3, 4 and 6. During this conversation, the maintenance staff indicated that the home did not purchase any new beds and that he was not made aware of any beds that were being removed or replaced. He further indicated that nothing was done with the identified beds with failed zones of entrapment. During the conversation, the maintenance staff indicated that he has

reported the results of the bed system evaluations to his supervisor at the time of evaluation and he was unsure if it was communicated to the DOC or the Executive Director.

During a review of the documentation provided by the maintenance staff titled "Facility Entrapment Inspection sheet" used to perform the bed system evaluation, Inspector #592 noted that out of five units, two units were not in the documentation. During a discussion with the maintenance staff, who indicated that he was unable to find the bed system evaluation documentation for the Queen and the Parkdale unit.

A further review of the "Facility Entrapment Inspection sheet" was done by Inspector #592.

The sheet indicated that in a specified resident's bedroom, bed #080, which at the time of the evaluation was occupied by resident #040, was identified to have failed in zone 2, 3, 4 and 6.

The sheet further indicated that in a specified resident's bedroom, bed #029, which at the time of the evaluation was occupied by resident #036, was identified to have a therapeutic air mattress for which zone 1 was determined to have passed. 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. At the time of the evaluation, resident #036's mattress had been changed and was no longer a therapeutic air surface.

The sheet also indicated that in a specified resident's bedroom, bed identified by #119 which at the time of the evaluation was occupied by resident #029 was identified to have failed in zone 2, 3, 4 and 6.

On May 29, 2017, Inspector #592 and maintenance staff #102 observed the beds in the above three specified resident's bedrooms.

It was observed by the Inspector and maintenance staff #102 that bed #80 was still in a specified resident's bedroom, in use by resident #040. Zones 2, 3, 4 and 6 had been identified as failed.

It was observed by the Inspector and maintenance staff #102 that in a specified resident's bedroom, bed #029 was now in use for resident #036. At the time of the

bed system evaluation process, this bed had been in a specified resident's bedroom, and zones 2, 3, 4 and 6 were identified as failed. Related to a specified resident's bedroom, it was noted that a new bed system had been put into place for resident #036 following the observation of Inspector #592 on May 24, 2017. It was observed that the new bed system did not have a number. The maintenance staff #102 confirmed to the Inspector that the new bed system had not been evaluated.

In summary, the bed system evaluation document indicated that a total of 76 beds were evaluated and on this total, 52 beds were flagged with failed zones of entrapment.

On May 30, 2017, in a discussion with the DOC 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 DOC also indicated that no steps were taken to prevent resident entrapment with regards to the beds identified with failed zones of entrapment. The DOC also stated that she was not familiar with the Health Canada companion document that provides guidance for the clinical assessment of residents when bed rails are used.

The non-compliance described above is widespread and presents the potential for actual harm to residents. [s. 15. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not supervised by staff.

On May 24, 2017, at 0940 hours, Inspector #592 observed on the second floor on Parkdale home area one soiled linen room unlocked. The soiled linen room led to another area which had a panel indicating "nurse call system controllers". The door to this area was also observed to be unlocked and open. The soiled linen room also contained plastic containers with soiled linen and was accessible to residents. At the time of the observation there were no staff present in the area.

On May 24 and June 01, 2017, between 0930 and 1030 hours, Inspector #592 observed on the second floor on Queens home area one soiled linen room unlocked. The soiled linen room led to another area which had a panel indicating "nurse call system controllers". The door to this area was also observed to be unlocked and open. Blue wires were observed coming out from a white pail and was accessible to residents. At the time of the observation there were no staff present in the area.

On May 24 and June 01, 2017, at 0950 hours, Inspector #592 observed on the second floor on Queens home area one storage room unlocked. The storage room was containing mechanical lifts, battery chargers and one electrical panel that was accessible to residents. At the time of the observation there were no staff present in the area.

On May 24, 2017, at 0953 hours, Inspector #592 observed on the third floor on

Rosemount home area one soiled linen room unlocked. Two sharp containers with no lids were observed containing disposable used razors on a counter. The soiled linen room led to another area which had a panel indicating "nurse call system controllers". The door to this area was also observed to be unlocked and open. The soiled linen room was accessible to residents. At the time of the observation there were no staff present in the area.

On May 24, 2017, at 1010 hours, Inspector #592 observed on the third floor on Wellington home area one storage room unlocked. The storage room was containing mechanical lifts and battery chargers and one electrical panel that was accessible to residents. At the time of the observation there were no staff present in the area.

Further Inspector #592 observed that there were no call bells in the above identified soiled linen and storage rooms.

On May 24, 2017, at 1330 hours, in an interview with RN #100, Inspector #592 enquired about the disposable razors kept in the soiled linen room on the Rosemount home area. The RN #100 accompanied Inspector #592 to the soiled linen room which was unlocked. The RN indicated that the room was expected to be closed and locked at all times. She further indicated that the razors left in the sharp container was a potential risk for the resident and she locked the soiled lined room door.

On June 01, 2017, at 1345 hours, Inspector #592 observed on the first floor on Gladstone home area (secured unit) one soiled linen room unlocked. The soiled linen room led to another area which had a panel indicating "nurse call system controllers". The door to this area was also observed to be unlocked and open. The soiled linen room also contained plastic containers and was accessible to residents with no staff supervision.

On June 01, 2017, in an interview with the DOC, she indicated to Inspector #592 that the soiled linen rooms as well as the storage rooms on all of the resident home areas were considered as non-residential areas and were expected to be closed and locked at all times. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas must be kept closed and locked when they are not supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred immediately reported the suspicion and the information upon which it was based to the Director.

On a specified date and time, the Ministry of Health and Long-Term Care (MOHLTC) after-hours pager was contacted to notify the Director of an allegation of staff to resident abuse, and after eight days a Critical Incident Report (CIR) was submitted under LTCHA, s. 24.

According to the licensee's internal investigation, an allegation of staff to resident abuse involving resident #062 and PSWs #146, #124 and #153 and RPN #106 was brought to the attention of the then acting DOC on a specified date, which was eight days after the occurrence of the incident. The incident is alleged to have occurred during resident #062's shower.

According to the resident #062's written plan of care, the resident required two person extensive assistance for bathing due to responsive behaviours, including resistiveness to care.

The allegation of abuse which was brought to the attention of the acting DOC on a specified date, was not immediately reported to the Director; it was reported until next day at a specified time. In an interview with the DOC on June 09, 2017, she indicated that she knew that the allegation of abuse had to be reported to the Director immediately and could not account for the delay in reporting. (Log 031786-16) [s. 24. (1)]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred immediately reported the suspicion and the information upon which it was based to the Director.

On a specified date and time the MOHLTC after-hours pager was contacted to notify the Director of an allegation of staff to resident abuse, and after eight days CIR was submitted, under LTCHA, s. 24.

According to the licensee's internal investigation, an allegation of staff to resident abuse involving a resident being force fed by PSW #153 was brought to the attention of the then acting DOC on a specified date, which was 15 days after the occurrence of the incident.

On June 09, 2017, the DOC confirmed that the resident identified in the CIR was resident #068. According to resident #068's written plan of care, the resident requires total assistance for feeding and is to be fed slowly.

The allegation of abuse which was brought to the attention of the acting DOC on a specified date, was not immediately reported to the Director; it was reported until next day at a specified time. In an interview with the DOC on June 09, 2017, she indicated that she knew that the allegation of abuse had to be reported to the Director immediately and could not account for the delay in reporting. (Log #031783-16) [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Critical Incident Report (CIR) was submitted to the Director by the licensee, and indicated that on a specified date, resident #063 was found on the floor in the home's lounge area. The CIR further indicated that resident #063 was sent to the hospital for an assessment and was diagnosed with a injury, which resulted in a significant change in the resident's health status.

On June 06, 2017, Inspector #573 reviewed resident #063's written plan of care in place at the time of fall incident, which indicated that resident was at high risk for falls. A review of the resident's progress notes indicated that prior to fall incident on a specified date, resident #063 had a one fall incident with injury and a near fall incident on same specified month in 2016. Resident #063's progress notes further indicated that resident had a fall incident on a identified date in 2017, that caused an injury for which the resident was taken to hospital. A review of the resident's health care record shows that no post-fall assessment, using a clinically appropriate tool specifically designed for falls, was done for any of the above identified resident #063's fall incidents.

On June 06, 2017, Inspector #573 spoke with home's DOC and RAI-Coordinator, both indicated to the inspector that when a resident has fallen, registered nursing staff must do a post fall assessment, which is documented in the resident's progress notes and to complete a fall incident report in the Point Click Care.

Further the DOC and the RAI- coordinator indicated to Inspector #573 that the home does not have a clinically appropriate assessment instrument that is specifically designed for falls. (Log #028789-16) [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #002 was admitted on a specified date with several diagnoses. A review of resident #002's current plan of care was completed by Inspector #592. The resident was identified as having altered skin integrity. The current plan of care indicated that there was three current pressure ulcers identified on specified areas of the resident's body. For the purpose of this report, those ulcers will be called

“wound A”, "wound B" and "wound C".

Related to "wound A”:
The most recent wound assessment on a specified date, identified "wound A", a pressure ulcer at an identified stage, and described the wound's colour, wound base and size. It was also noted that "wound A" had started 11 days prior to the date of the most recent wound assessment report.

Related to "wound B”:
In a review of resident #002’s progress notes of the two other current wound ulcers with the presence of RN #112 it was observed that "wound B", located at an identified site, and had started on a specified date. "Wound B" was described as a pressure ulcer at an identified stage, and the edges and base of the wound was described, as well as the size. Upon a review of the resident #002's progress notes both Inspector and the RN were unable to find skin assessments performed six separate identified weeks.

Related to "wound C”:
It was further observed by Inspector #592 and RN #112 that "wound C" started on a specified date, and both Inspector and the RN were unable to find any skin assessment performed between two specified dates, 12 days apart. The most recent skin assessment described the wound stage, size and described the presence of wound discharge.

On June 02, 2017, in an interview with RN #112, she indicated to Inspector #592 that she was the home's skin and wound resource person as she was certified for Enterostomal Therapist (ET). She further indicated that resident #002 was still exhibiting altered skin integrity to four specific areas, however only three areas required specific treatments as the other area were only to be monitored. She further indicated to the Inspector #592 that a weekly skin assessment was performed for each resident exhibiting altered skin integrity including resident #002 for the three current pressure ulcers using the wound tracker located in their electronic software. When the Inspector enquired to RN #112 about the weekly skin assessment for "wound A" she indicated that no other skin assessment was performed during the past three weeks for this wound.

In a discussion with RN #112, she indicated to Inspector #592 that resident #002 should have had a weekly skin assessment completed as part of the home’s wound care program. She further indicated that there was no indication for the

nursing staff of when to perform the skin assessment on the electronic software, therefore the skin assessment was often missed and was not done weekly as clinically indicated.

In an interview with the DOC, she indicated to Inspector #592 that a weekly skin assessment was expected for all altered skin integrity as per the home's skin and wound program. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for resident #058 who was demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions.

The Director of the MOHLTC was contacted on a specified date indicating that resident #056 and resident #058 had been found lying in bed together. A Critical Incident Report (CIR) was then submitted, under LTCHA, s. 24.

Inspector #551 reviewed the health care records of resident #056 and resident #058 and interviewed staff members. Resident #056 was admitted to the home on a specified date and had mild cognitive impairment. Resident #058 was admitted to the home on a specified date and had moderately severe cognitive impairment.

Resident #058 demonstrated responsive behaviours of a sexual nature towards co-residents, particularly resident #056 on multiple occasions.

On five different occasions, resident #058 and resident #056 were found lying in bed together. On each of these occasions, the residents were separated. On several different occasions, resident #058 and resident #056 were found talking, holding hands or kissing. The residents were separated and/or told that these actions were not appropriate.

On several different occasions, resident #058 made comments and/or gestures of a sexual nature towards different co-residents and resident #056.

Following the forth incident of resident #058 and resident #056 being found lying in bed together, a progress note was written by RN #142 in resident #056's chart indicating that resident #056's SDM was upset by the actions of resident #056 and resident #058. According to the progress note, the RN explained to the SDM that measures would be put in place immediately to keep the residents separated.

In an interview, the DOC confirmed that on a specified date, she received an email from RN #142 indicating that interventions were needed to keep resident #056 and resident #058 separated. The DOC indicated that no interventions were put in place, and no reassessment of resident #058's responsive behaviours was completed as the residents appeared to know what they were doing in the moment

and were enjoying each other's company.

Following the fifth incident of resident #058 and resident #056 being found lying in bed together, consent was obtained from resident #058's SDM for a referral to the ROH outreach program. On a specified date, resident #058 was assessed by Geriatric Psychiatry, and medication changes were recommended. Resident #058 continued to display responsive behaviours of a sexual nature to resident #056 and co-residents.

Approximately one month after resident #058 began displaying responsive behaviours, interventions were added to the written plan of care with the goal of minimizing his/her sexually inappropriate behaviour in the next quarter.

On a specified date, resident #056 moved to a different unit. Progress notes indicate that resident #058's responsive behaviours of a sexual nature continued, including on two specific days.

On June 02 and 06, 2017, respectively, RPN #113, RPN #138 and RPN #117 indicated that a reassessment of resident #058's responsive behaviours was not completed. RPN #113, RPN #138 and RPN #117 indicated that when resident #056 and resident #058 were found together, they were separated by staff because resident #056's SDM did not want them to be together. RPN #117 stated that she felt that in the moment, resident #058 and resident #056 knew what they were doing.

In an interview on June 01, 2017, the DOC indicated that it was believed that resident #056 and resident #058 were willing participants in the encounters and that neither showed any signs of distress or objection to the encounters. The DOC indicated that resident #058's responsive behaviours towards resident #056 were not reassessed before resident #056 was moved to a different unit. The DOC indicated that her direction to staff was to let them be when found together.

In an interview on June 09, 2017, the ED indicated that he had received a call from resident #056's SDM, and that the resident's SDM was concerned about the behaviour of resident #058 towards resident #056. The ED stated that resident #058 was the resident displaying the unwanted behaviour and that a bed on another unit became available so an internal transfer for resident #056 took place "so the behaviour between resident #058 and resident #056 must have just happened".

Resident #058 displayed responsive behaviours of a sexual nature on numerous occasions. Actions were not taken to respond his/her responsive behaviours through reassessments and interventions when initial interventions were not effective. [s. 53. (4) (c)]

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 actions (including assessments, reassessments and interventions) are taken to respond to the needs of the resident #58's identified responsive behaviours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM was notified within 12 hours upon the licensee becoming aware of an allegation of staff to resident abuse.

An allegation of staff to resident #062 abuse was reported to the licensee's then acting DOC, on a specified date, which was eight days after the occurrence of the incident. The initial report was submitted to notify the Director through the MOHLTC after-hours pager on the next day.

According to the after-hours pager report, which was submitted more than thirty six hours after the licensee became aware of the allegation, the resident #062's SDM had not been notified of the alleged abuse. According to the CIR, which indicated that the resident's SDM was notified of the allegation, although the date of the notification was not specified, and would have exceeded the twelve hour time frame for SDM notification. The CIR was submitted by the ED who could not indicate when the resident's SDM was notified of the alleged abuse. (Log #031786-16) [s. 97. (1) (b)]

2. The licensee has failed to ensure that the resident's SDM was notified within 12 hours upon the licensee becoming aware of an allegation of staff to resident abuse.

An allegation of staff to resident #068 abuse was reported to licensee's then acting DOC on a specified date, which was 15 days after the occurrence of the incident. The initial report was submitted to notify the Director through the MOHLTC after-hours pager on the next day.

According to the after-hours pager report, which was submitted more than thirty six hours after the licensee became aware of the allegation, the resident #068's SDM had not been notified of the alleged abuse. According to the CIR, which indicated that the resident's SDM was notified of the allegation, although the date of the notification was not specified, and would have exceeded the twelve hour time frame for SDM notification. The CIR was submitted by the ED who could not indicate when the resident's SDM was notified of the alleged abuse. (Log #031783-16) [s. 97. (1) (b)]

3. The licensee has failed to ensure that the resident's SDM was notified of the results of the abuse investigation immediately upon the completion of the investigation.

An allegation of staff to resident #062 abuse was reported to the licensee's then acting DOC, on a specified date.

An Abuse Investigation Report was submitted to the licensee by the Salvation Army Territorial Abuse Advisor on specified date. In an interview with the DOC, she indicated that the licensee had been made aware prior the report submission that it was recommended that the PSWs and RPN involved in the incident be exonerated of the allegation of abuse, and that these staff members, who had been on administrative leave, were permitted to return to work on identified dates.

The licensee's investigation was completed on or before a specified date, when two PSW staff members were permitted to return to work. Nine days after the CIR was amended after the completion of the investigation, which indicated that the resident's SDM's response was that she/he was concerned, worried and fearful. The DOC and ED were unable to confirm that the resident #062's SDM was notified of the results of the abuse investigation immediately upon completion of the licensee's investigation. (Log #031786-16) [s. 97. (2)]

4. The licensee has failed to ensure that the resident's SDM was notified of the results of the abuse investigation immediately upon the completion of the investigation.

An allegation of staff to resident #068 abuse was reported to the licensee's then acting DOC, on a specified date.

An Abuse Investigation Report was submitted to the licensee by the Salvation Army Territorial Abuse Advisor on specified date. In an interview with the DOC, she indicated that the licensee had been made aware prior the report submission that it was recommended that PSW #153 involved in the incident be exonerated of the allegation of abuse, and that the PSW, who had been on administrative leave, was permitted to return to work on a specified date.

The licensee's investigation was completed on or before a specified date, when the PSW staff member was permitted to return to work. Nine days after the CIR was amended after the completion of the investigation, which indicated that the resident #068's "relatives were notified and explanation given to family members what we knew at the time". The DOC and ED were unable to confirm that the resident #068's SDM was notified of the results of the abuse investigation immediately upon completion of the licensee's investigation. (Log #031783-16) [s. 97. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance - a) to ensure that the resident's substitute decision-maker was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident b) to ensure that the resident's substitute decision-maker was notified of the results of the abuse investigation immediately upon the completion of the investigation, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents received training in the area of abuse recognition and prevention annually.

In an interview with the Director of Employee Relations, he indicated that the licensee's training on abuse recognition and prevention is titled One is One too Many. The Director of Employee Relations indicated that in 2016, all staff who provide direct care to residents were expected to complete this on-line through Surge Learning.

A copy of the One is One too Many course completion list, supplied by the Director of Employee Relations showed that in 2016, seventy three out of one hundred and forty two staff members, specifically PSW, RPN or RN did not complete the One is One too Many course. (Log #031786-16/ #031783-16) [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents received annual training related to home's Zero Tolerance of Abuse and Neglect policy, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #045 as specified in the plan.

The plan of care for resident #045 indicated that the resident is at risk for falls characterized by a history of falls, non-compliance with mobility aides and unsteady gait.

Over the last two months the resident's health care record notes four documented fall incidents on specified dates. The description of each of the falls indicates that the falls occurred while the resident was attempting to leave the bed during the early morning hours. The plan of care was updated on a specified month in 2016, to include that resident #045 is to be up out of bed before 0700 hours and in the wheelchair to prevent resident from getting out of bed without assistance and falling.

The progress notes and related risk management reports demonstrate that the resident's falls on two specified dates, occurred at 0815 and 0730 hours; both with injuries. In an interview with RPN #113, reported that the night shift staff are to get the resident up out of bed before 0700 hours as the resident is known to get out of bed without assistance which may lead to falls.

For resident #045's fall incident with injury on two specified dates, resident #045's plan of care was not provided to the resident as set out by the plan of care, as it relates to the provision of morning care for fall prevention. [s. 6. (7)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #002 was admitted on a specified date with several diagnoses. A review of resident #002's current plan of care was completed by Inspector #592. The resident was identified as having altered skin integrity. The current plan of care indicated that there was three current pressure ulcers identified on specified areas of the resident's body requiring treatments as per the Treatment Administration Record (TAR). For the purpose of this report, those ulcers will be called "wound A", "wound B" and "wound C".

The most recent wound assessment on a specified date, identified "wound A", a pressure ulcer at an identified stage, and described the wound's colour, wound base and size. It was also noted that "wound A" had started 11 days prior to the date of the most recent wound assessment report. The TAR dated on a specified month indicated specific treatment for "wound A" and also indicated to change the dressing every three days and as needed.

On June 02, 2017, resident #002's TAR was reviewed by Inspector #592 with the presence of RN #112 who was identified to be the home's skin resource person. Upon review, it was observed that there was no documentation to support that the treatment was provided to resident #002's "wound A" between two specified dates, five days apart, as well as between two other specified dates, five days apart. The TAR indicated that the treatment was to be provided to the resident on those specified dates. RN #112 confirmed that the treatment for "wound A" was to be provided every three days and that there was no documentation to support that the treatment was provided to resident #002 on these dates.

In a review of resident #002's progress notes, it was indicated that "wound B" located at an identified site, and had started on a specified date. "Wound B" was described as a pressure ulcer at an identified stage, and the edges and base of the wound was described, as well as the size. The TAR dated on a specified month indicated identified treatment for "wound B" and also indicated to change the dressing every three days and as needed.

It was observed by Inspector #592 that there was no documentation to support that the treatment was provided to resident #002's "wound B" between two specified dates, five days apart, as well as between two specified dates, five days apart. The TAR indicated that the treatment was to be provided to the resident on those specified dates. RN #112 who was present during the review of resident #002's health care record, confirmed with Inspector #592 that the treatment for "wound B" was to be provided every three days and that there was no documentation to support that the treatment was provided to resident #002 on these dates.

Further review of resident #002's progress notes it was indicated that "wound C" located at an identified site, and had started on a specified date. "Wound C" was described as a pressure ulcer at an identified stage, and the edges and base of the wound was described, as well as the size. The TAR dated on a specified month indicated identified treatment for "wound B" and also indicated to change the dressing every three days and as needed.

It was observed by Inspector #592 that there was no documentation to support that the treatment was provided to resident #002's "wound C" between two specified dates, five days apart. The TAR indicated that the treatment was to be provided to the resident on the specified dates. RN #112 who was present during the review of the resident #002's health care record, confirmed with Inspector #592 that the treatment for "wound C" was to be provided every three days and that there was no documentation to support that the treatment was provided to resident #002 on that day. [s. 30. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Service Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if, the use of the PASD has been consented to by the resident or, if the resident is incapable, a Substitute Decision-Maker (SDM) of the resident with authority to give that consent.

In accordance with LTCHA 2007, s. 33 and O. Reg 79/10, s.111, a PASD is a device used to assist a person with a routine activity of living that limits/ inhibits freedom of movement and which the resident is unable to physically or cognitively remove. The licensee shall ensure that for those residents using devices as PASDs, under section 33 of the Act, the use of the PASD is reasonable and that consent has been obtained and documented from the resident or by the resident's substitute decision maker.

On May 26 and 31, 2017, Inspector #573 observed resident #012 was sitting in a wheel chair with a table top. On May 31, 2017, when Inspector #573 requested resident #012 to remove the wheel chair table top, resident could not remove the table top from the wheel chair. Inspector #573 reviewed resident #012's current written plan of care in place which identified that the use of wheel chair table top as a PASD, to provide assistance with the meals, holding cup, pen and calendar. Further it was documented in the written plan of care that resident was not able to remove the table top.

On May 31, 2017, Inspector #573 spoke with the PSW #134, who indicated that resident #012's wheelchair table top is used to assist the resident with the meals, drinks and placing resident's pen and calendar on the table top. Further PSW #134 indicated to inspector that staff will apply and remove the table top for the resident.

On May 31, 2017, during an interview, RPN #135 indicated that the wheelchair table top was used for resident #012 as a PASD. RPN #135 indicated to the inspector that resident was unable to physically remove the table top. Inspector #573 reviewed resident #012's health care records with RPN #135 and was unable to locate a consent for the use of the table top as a PASD either from the resident nor from the resident's SDM. [s. 33. (4) 4.]

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff received training on the licensee's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

According to LTCHA, s. 2 (1), "staff" means persons who work at the home pursuant to a contract or agreement with the licensee.

On a specified date and time, the after-hours pager was contacted to notify the Director of two separate allegations of staff to resident abuse, and Critical Incident Reports were submitted, under LTCHA, s. 24. The two allegations of abuse were brought to the attention of the then acting DOC on a specified dates, which was eight and 15 days after the occurrence of the incident.

In an interview with the DOC on June 09, 2017, she indicated that prior to beginning of the nursing students placement on a specified date, the nursing students did not receive training on the home's abuse policy. The DOC indicated that as a result of the licensee's investigation, a new and specific orientation had been implemented and included training on the licensee's zero tolerance of abuse and neglect policy. (Log #031786-16/ #031783-16) [s. 76. (2) 3.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included (i) the names of all residents involved in the incident.

On a specified date and time, the MOHLTC after-hours pager was contacted to notify the Director of an allegation of staff to resident abuse which involved PSW #153 force feeding a resident, and CIR was submitted, under LTCHA, s. 24.

The name of the resident who was allegedly force fed was not included in the after-hours pager report or the CIR.

On June 08, 2017, the ED who submitted the CIR indicated to the inspector that the report to the Director did not include the name of the resident. (Log #031783-16) [s. 104. (1) 2.]

2. The licensee has failed to ensure that the report to the Director included the outcome or current status of the individual or individuals who were involved in the incident.

According to the CIR amended on specified date and time, the outcome/current status of the individual(s) who was/were involved in this occurrence is specified as "lengthy conversation" and "numerous different days of conversation", respectively.

In an interview with the ED on June 08, 2017, he indicated that he completed the original CIR submission, and that the Assistant DOC, at the time who no longer works at the home, completed any amendments. He could not elaborate on how these conversations reported the outcome or status of resident #062 to the Director. (Log #031786-16) [s. 104. (1) 3.]

3. The licensee has failed to ensure that the final report was made to the Director within 21 days unless otherwise specified by the Director.

A memo sent to Long-Term Care Home Licensees and Administrators on February 12, 2015, by the Director specified that if the licensee cannot provide all of the material mandated by subsection 104 (1) then the licensee must submit a preliminary report to the Director within 10 days of the licensee becoming aware of the incident and must provide a final report within a period of time specified by the Director. The memo dated February 12, 2015, referenced a separate memo dated March 28, 2012, in which the Director identified that the final report must be submitted within 21 days unless otherwise specified by the Director.

On a specified date and time, the after-hours pager was contacted to notify the Director of an allegation of staff to resident #062 abuse, and after eight days a CIR

was submitted to the MOHLTC.

The licensee was provided the support of the Territorial Abuse Advisor of the Salvation Army (licensee) to complete the abuse investigation, and a report was submitted on a specified date, to the home's management.

After 30 days a final report to the MOHLTC Director was submitted on a specified date, when the status of the CIR was changed from 'submitted' to 'amended'. This exceeds the legislative requirement of submitting the final report within 21 days. (Log #031786-16) [s. 104. (3)]

4. The licensee has failed to ensure that the final report was made to the Director within 21 days unless otherwise specified by the Director.

On a specified date and time, the after-hours pager was contacted to notify the Director of an allegation of staff to resident #068 abuse, and a CIR was submitted to the MOHLTC on a specified date.

The licensee was provided the support of the Territorial Abuse Advisor of the Salvation Army (licensee) to complete the abuse investigation, and a report was submitted on a specified date to the home's management.

The final report to the MOHLTC Director was submitted after 30 days on a specified date. This exceeds the legislative requirement of submitting the final report within 21 days. (Log #031783-16) [s. 104. (3)]

WN #14: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident #036'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.

Resident #036's most recent MDS assessment conducted at a specified date, identified the daily use of a trunk restraint. The inspector reviewed resident #036's health care records for the use of a restraint, which included the SDM's consent and a corresponding physician's order for the use of wheelchair lap belt as a restraint.

On June 01, 2017, Inspector #573 reviewed resident #036's written plan of care in place which indicated that "Restraint- Application of an external device for the prevention of injury to (self) related to diagnoses, No falls, Seatbelt for safety observe every hour while in the wheel chair and document. Undo, re-apply seat belt and reposition resident every 2 hours".

Inspector #573 reviewed resident #036's health record including Treatment Administration Record (TAR) and was unable to find any records that the resident's condition was reassessed for the effectiveness of the wheelchair seatbelt restraint.

On June 01, 2017, Inspector #573 spoke with RPN #144, who indicated that resident #036's wheel chair seat belt restraint was frequently monitored. Further RPN #144 indicated that resident's condition was not reassessed for the effectiveness of the restraining for every eight hours by the registered nursing staff.

On June 05, 2017, Inspector #573 spoke with DOC, who indicated that registered nursing staff must reassess and record the resident's response and the effectiveness of the restraint every eight hours in the electronic TAR. [s. 110. (2) 6.]

Issued on this 30 day of August 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
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347 rue Preston, bureau 420
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : ANANDRAJ NATARAJAN (573) - (A1)

Inspection No. / No de l'inspection : 2017_593573_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 008230-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Aug 30, 2017;(A1)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

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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 Administrator / Nom de l'administratrice ou de l'administrateur : Roy Snow

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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 :

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

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

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

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

Order / Ordre :

Ontario

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee is ordered to:

1. Re-evaluate all bed systems where bed rails are used in the home, in accordance with evidence-based practices. (This must be completed within 14 days of this order being served).

2. Ensure that an interdisciplinary team assess all residents in the home who use any type of bed rails, in accordance with the 2003 FDA prevailing practices document "Clinical Guidance For the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings". The assessment shall include the assessment of the relative risk of using the bed rails compared with not using them for an individual resident. The assessment is to occur before a decision to use or to discontinue the use of a bed rail is made.

3. Ensure that the above assessments are documented including the names of team members participating in the assessment, the results of the assessment including the risk benefit assessment, and the recommendations.

4. 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 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.

5. Establish 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. The licensee failed to comply with section 15.(1)(a)(b) of the regulation in that the licensee failed to ensure that when bed rails are used 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 and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On August 21, 2012, a memo 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 titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the memo, it is written that this Health Canada Guidance Document is expected to be used "as a best practice document". The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zone 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zone1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

The Health Canada 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 Health Canada 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” (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment for residents 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, but not limited to, the resident’s

right to participate in the care planning process, the resident's medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. 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 health care 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.

On May 24, 2017, Inspector #592 and Inspector #573 observed that resident #029's bed had one ¾ rail that was elevated from the head of the bed. Inspectors observed a significant gap between the bed mattress and the bed rail (Zone 2). When Inspector #573 further inspected the rail, it was observed that the bed rail further expanded outward leaving a wider gap between the bed mattress and the rail of more than six inches with compression of the mattress.

Inspector #592 brought forward her observation to the Executive Director due to potential safety risk. The Executive Director accompanied Inspector #592 to resident's #029's room. When the rail was showed to the Executive Director, he indicated that the gap between the bed mattress and the rail was a risk of entrapment for the resident therefore, he indicated that the bed would be changed immediately to ensure the resident's safety.

The Inspector reviewed resident #029's plan of care in place (as defined by the home) that indicated the resident requires full bed rails and staff to observe the resident every hour while in the bed and document.

On May 25, 2017, Inspector #592 observed that resident #040's bed had one ¾ rail that was elevated from the head of the bed. A gap of approximately four inches was observed between the bed mattress and the rail. When Inspector #593 inspected the bed rail, the rail further expanded outward leaving a wider gap between the bed mattress and the rail of more than five inches with compression of the mattress.

On May 25, 2017, Inspector #592 observed that resident #036's bed had one ¾ rail elevated from the head of the bed. A gap of approximately four inches was observed between the bed mattress and the rail.

On May 26, 2017, in an interview with the DOC regarding the assessment process

for residents using bed rails. During the conversation, it was determined by the DOC that there was no formal assessment process for residents using bed rails. The DOC also indicated when asked about the bed system evaluation that the maintenance staff #102 was the person responsible, therefore she did not have any documentation on bed system evaluation. The DOC further explained that in some cases, there has been discussion between the registered staff, residents and family members about the resident's need for a bed rail. As per the FDA clinical guidance document, residents are to be assessed to determine the risk of using bed rails.

On May 26, 2017, in an interview with the maintenance staff #102, who indicated that he was the person in charge of the beds where bed rails were used for conducting the bed system evaluation. He further indicated that the home does not have the tool to perform the evaluations on site but used a tool from an outside provider to conduct the bed system evaluations at that time. The maintenance staff #102 indicated that the bed system evaluations were conducted approximately one year to one and a half years ago and that several beds were flagged with failed zones of entrapment, specifically zone 2, 3, 4 and 6. During this conversation, the maintenance staff indicated that the home did not purchase any new beds and that he was not made aware of any beds that were being removed or replaced. He further indicated that nothing was done with the identified beds with failed zones of entrapment. During the conversation, the maintenance staff indicated that he has reported the results of the bed system evaluations to his supervisor at the time of evaluation and he was unsure if it was communicated to the DOC or the Executive Director.

During a review of the documentation provided by the maintenance staff titled "Facility Entrapment Inspection sheet" used to perform the bed system evaluation, Inspector #592 noted that out of five units, two units were not in the documentation. During a discussion with the maintenance staff, who indicated that he was unable to find the bed system evaluation documentation for the Queen and the Parkdale unit.

A further review of the "Facility Entrapment Inspection sheet" was done by Inspector #592.

The sheet indicated that in a specified resident's bedroom, bed #080, which at the time of the evaluation was occupied by resident #040, was identified to have failed in zone 2, 3, 4 and 6.

The sheet further indicated that in a specified resident's bedroom, bed #029, which at

the time of the evaluation was occupied by resident #036, was identified to have a therapeutic air mattress for which zone 1 was determined to have passed. 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. At the time of the evaluation, resident #036's mattress had been changed and was no longer a therapeutic air surface.

The sheet also indicated that in a specified resident's bedroom, bed identified by #119 which at the time of the evaluation was occupied by resident #029 was identified to have failed in zone 2, 3, 4 and 6.

On May 29, 2017, Inspector #592 and maintenance staff #102 observed the beds in the above three specified resident's bedrooms.

It was observed by the Inspector and maintenance staff #102 that bed #80 was still in a specified resident's bedroom, in use by resident #040. Zones 2, 3, 4 and 6 had been identified as failed.

It was observed by the Inspector and maintenance staff #102 that in a specified resident's bedroom, bed #029 was now in use for resident #036. At the time of the bed system evaluation process, this bed had been in a specified resident's bedroom, and zones 2, 3, 4 and 6 were identified as failed. Related to a specified resident's bedroom, it was noted that a new bed system had been put into place for resident #036 following the observation of Inspector #592 on May 24, 2017. It was observed that the new bed system did not have a number. The maintenance staff #102 confirmed to the Inspector that the new bed system had not been evaluated.

In summary, the bed system evaluation document indicated that a total of 76 beds were evaluated and on this total, 52 beds were flagged with failed zones of entrapment.

On May 30, 2017, in a discussion with the DOC 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 DOC also indicated that no steps were taken to prevent resident entrapment with regards to the beds identified with failed zones of entrapment. The DOC also stated that she was not familiar with the Health Canada companion document that provides guidance for the clinical assessment of residents when bed rails are used.

The non-compliance described above is widespread and presents the potential for actual harm to residents. (592)

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

Nov 22, 2017(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 30 day of August 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ANANDRAJ NATARAJAN - (A1)

Service Area Office /
Bureau régional de services : Ottawa