Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 24, 2017	2017_617148_0027	014857-17	Resident Quality Inspection

Licensee/Titulaire de permis

458422 ONTARIO LIMITED
220 EMMA STREET CORNWALL ON K6J 5V8

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

SANDFIELD PLACE
220 EMMA STREET CORNWALL ON K6J 5V8

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

AMANDA NIXON (148), MELANIE SARRAZIN (592), MICHELLE EDWARDS (655)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 29, 30, 31 and September 1, 5, 6, 7, 8, 11, 12, 15 and 18, 2017

The following complaint logs were completed as part of this RQI inspection: 013592 -17 and 019446-17, related to staffing of registered nurses; 001460-17 related to alleged abuse and improper care.
The following critical incident logs were completed as part of this RQI inspection: 001563-17 and 031558-16, related to an injury of a resident that resulted in transfer to hospital and change in health status; 026708-16, related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Nurse Practitioner, RAI Coordinator, Food Service Supervisor (FSS), Activity Supervisor, Registered Dietitian (RD) , Administrative Assistant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activity/Restorative Aides, Physiotherapy Assistant, Dietary Aides (DA), Cook, Maintenance staff, Housekeeping staff, Residents and Family Members.

In addition, the inspectors observed resident care and services in the home, resident-staff interactions, the resident's home environment, meal services and medication administration. The inspectors reviewed resident health care records, relevant polices and procedures including those related to infection control, staffing plans, resident and family council meeting minutes and documents pertaining to bed systems maintained in the home and resident assessments related to the use of bed rails.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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 has failed to ensure that where 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.

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

The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003) (the companion document). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. It is identified in the document that the population at risk for entrapment includes residents

who are frail or elderly, and/or those who have conditions which cause them to move about in bed and/or try to exit from the bed. This includes conditions such as: agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction and acute urinary retention that cause them to move about the bed or try to exit from the bed. Other contributing risk factors are also identified in the companion document, including the absence of timely nursing care and technical issues related to the bed system.

According to the companion document, evaluation is needed to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. A decision regarding the use of bed rails is to be made within the context of an individualized resident assessment using an interdisciplinary team, and with input from the resident and family or SDM. This process is to include 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 consider numerous factors including (but not limited to) the resident's medical needs, sleep habits and patterns, cognition, mobility (in and out of bed), risk of falling, and the sleeping environment.

Diagnoses, symptoms, conditions and/or behavioral symptoms for which the use of a bed rail is being considered are to be addressed. Nursing/medical and environmental interventions are to be identified. If clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed need; or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used. Documentation of the risk-benefit assessment is required. The decision to use bed rails is to be approved by the interdisciplinary team that assessed the resident; and the effectiveness of the bed rail is to be reviewed regularly.

On August 29, 2017, Inspector #655 observed the bed system belonging to resident #033. Two ¼ length bed rails were observed to be in the up position at that time. At the time of the observation, both rails were observed to be slightly loose. In addition, there was a hand-width space between the headboard and the top of the mattress; and no mattress keepers were observed. On September 7 and again on September 12, 2017, Inspector #655 observed the same two ¼ length bed rails to be in the up position.

On August 29, 2017, Inspector #655 observed the bed system belonging to resident #034. From the foot of the bed, the left ¼ length bed rail was observed to be in the up position at that time. At the time of the observation, the left rail was observed to be loose; and there was a hand-width space between the inside surface of the left rail and the mattress. On September 7 and again on September 12, 2017, the same ¼ length bed rail

was observed to be in the up position.

On August 29, 2017, Inspector #655 observed the bed system belonging to resident #036. At the time of the observation, two ¼ length rails were in the up position. From the foot of the bed, the right rail was in the assist position (vertical) and the left rail was in the guard position (horizontal). At the time of the observation, the right assist rail was observed to be loose; and there was a hand-width space between the headboard and the mattress and between the footboard and the mattress. On September 7 and again on September 12, 2017, both bed rails were observed to be in the same up positions.

On August 30, 2017, Inspector #655 observed the bed system belonging to resident #028. From the foot of the bed, the left ¾ length bed rail was observed to be in the up position at that time. At the time of the observation, a hand-width space was observed between the headboard and the mattress. The mattress was not squarely on the mattress deck – an area of the upper left portion of the mattress deck was exposed, creating a hand-width space between the inside surface of the left rail and the outside edge of the mattress. There were no mattress keepers observed on the bed system. The same rail was observed to be in the up position on September 7 and again on September 12, 2017.

On August 30, 2017, Inspector #655 observed the bed system belonging to resident #038. Two ¼ length bed rails were observed to be in the up position at that time. From the foot of the bed, the right rail was observed to be in the guard position (horizontal) and the left rail was observed to be in the assist position (vertical). At the time of the observation, the left assist rail was looser when compared to the right rail. There was a hand-width space between the headboard and the mattress; and between the footboard and the mattress. On September 7 and again on September 12, 2017, the same two bed rails were observed to be in the up position.

During an interview on September 8, 2017, PSW #108 indicated to inspector that all five of the above-noted residents (#'s 028, 033, 034, 036, and 038) use one or more bed rails regularly. PSW #108 was unable to speak to a process in place for assessing residents prior to the implementation of bed rails; however, PSW #108 indicated to Inspector #655 that any assessment that is done would be done by a member of the registered nursing staff.

During an interview on September 8, 2017, RN #113 referred to a "Bed Rail Assessment" form that is used to assess residents for the use of bed rails. RN #113 indicated to

Inspector #655 that the purpose of the "Bed Rail Assessment" is to determine whether a given resident is safe to have a bed rail or whether it would be safer for that resident not to have a bed rail. During the same interview, RN #113 indicated to Inspector #655 that the nurse does not normally complete the "Bed Rail Assessment"; rather, it is completed by the RAI Coordinator.

Inspector #655 reviewed the health care records belonging to the five above-noted residents (#'s 028, 033, 034, 036, and 038). On review of the residents' hard copy and electronic health care records, Inspector #655 was able to locate "Bed Rail Assessments" for two of the five residents – resident #034 and resident #036. The "Bed Rail Assessment" was completed over two years ago, for resident #024; and over one year ago, for resident #036.

On review of the "Bed Rail Assessment" forms completed for resident #034 and resident #036, it was found that the "Bed Rail Assessment" was not in accordance with the current prevailing practices identified in "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (U.S. FDA, 2003), one of the companion documents to the HC Guidance Document. The "Bed Rail Assessment" did not address, for example, the resident's sleep habits, sleeping environment or level of comfort in bed (i.e. pain, hypoxia). Factors such as toileting needs and medications were also not addressed in the "Bed Rail Assessment". In addition, no clear documentation of a risk-benefit analysis was observed.

Inspector #655 was unable to locate any documentation to indicate that resident #'s 028, 033, or 038 had been assessed for the use of bed rails prior to their implementation; nor any documentation to indicate that a risk-benefit analysis had been completed for any of these three residents with regards to the use of bed rails.

During an interview on September 12, 2017, the RN #100 was also unable to locate a "Bed Rail Assessment form" for resident #028, #033, or #038. According to the Registered Nurse, resident #028 was not assessed using the "Bed Rail Assessment" form because the bed rails in place for resident #028 were considered to be a restraint; and for that reason, resident #028 had been assessed using the "Restraint/PASD Assessment" form. During the interview, it was discussed that certain elements identified in the companion document (FDA, 2003) such as a residents toileting needs and comfort in bed were not addressed in either the "Bed Rail Assessment" or the "Restraint/PASD Assessment" forms. The Registered Nurse was unable to speak to a process through

which these considerations were made in the process of assessing resident's for the use of bed rails.

During interviews on September 6 and September 12, 2017, RAI Coordinator #119 indicated to Inspector #655 that the "Bed Rail Assessment" form was the only tool being used to assess residents for the use of bed rails. RAI Coordinator #119 was not aware of any processes in place through which the various elements outlined in the companion document (FDA, 2003) would be considered when assessing residents for bed rail use in the home. RAI Coordinator #119 further indicated to Inspector #655 that residents are assessed using the "Bed Rail Assessment" form on admission. At the same time, RAI Coordinator #119 indicated to Inspector #655 that quarterly assessments related to a residents' use of bed rails were primarily a "review", not documented, and done primarily when a bed rail is considered to be a restraint. RAI Coordinator #119 indicated to Inspector #655 that shorter bed rails are often implemented based on the request of the resident and/or family.

During the same interview, RAI Coordinator #119 confirmed that there had been no "Bed Rail Assessment" form completed for either resident #038 or resident #033. RAI Coordinator #119 indicated to Inspector #655 that the "Bed Rail Assessment" forms had been implemented approximately two years ago; and that residents' who were admitted prior to that time may not have been assessed for the use of bed rails prior to the bed rails being implemented.

Over the course of the inspection, it was also noted by Inspector #655 that resident #029 and #039 also used one or more bed rails. Inspector #655 was unable to locate a "Bed Rail Assessment" for either resident.

During an interview on September 15, 2017, the home's Administrator indicated to Inspector #655 the "Bed Rail Assessment" form is the only assessment tool being used to conduct a clinical assessment of resident with regards to bed rail use. The Administrator indicated to Inspector #655 that the purpose of the "Bed Rail Assessment" is to assess each resident for both the need and their safety in using bed rails.

The licensee has failed to ensure that where bed rails are used, residents, including resident #028, 029, 033, 034, 036, 038, and 039, are assessed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

In addition to providing guidance regarding the clinical assessment of residents, 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 (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

It is recognized in the HC Guidance Document that legacy beds have the potential for dimensional change over time through wear and tear or substitution of bed components. According to the HC Guidance Document, a bed system may require re-evaluation when there is reason to believe that a bed system component is worn (for example, the rails wobble or are loose). As indicated in the HC Guidance Document, a lateral shift and/or degree of play from a loosened bed rail is a factor which may increase the gap size in potential entrapment Zones 2 (under the rail, between supports), 3 (between the rail and the mattress), and 4 (under the rail at the ends of the rail).

On August 29 and August 30, 2017, Inspector #655 observed the bed systems belonging to resident #'s 028, 033, 034, 036, and 038. Each of the bed systems were observed to have one or more bed rails in the up position; and were observed to have one or more loose bed rails, and/or gaps between the mattress and a bed rail and/or foot or headboard, as previously described.

In May 2017, all bed systems in the home were evaluated in accordance with the methods outlined in the HC guidance document. The bed system evaluations were done by an outside service provider. Inspector #655 reviewed the results of the bed system evaluations on a document provided to Inspector #655 by the Administrator on September 7, 2017.

On the bed system evaluation results document, there was a note that read: "if zones 1-4 pass entrapment testing a passing grade will be issued". Another note that read: "If any zones between 1-4 fails entrapment testing a failing grade will be issued"; and, "if zones 5,6 or 7 fails then a passing grade is issued but these zones should be addressed to ensure resident safety".

According to the bed system evaluation results document, provided to Inspector #655 by the Administrator 36 out of 52 (over 69%) of the bed systems in the home were given a failing grade, as one or more of the potential zones of entrapment with prescribed

dimensional limits (zones 1-4) exceeded the prescribed dimensional limits.

Of the five bed systems that were observed by Inspector #655 on August 29 and August 30, 2017, all five were given a failing grade. Those were the bed systems belonging to resident #'s 028, 033, 034, 036, and 038. According to the bed system evaluation results document:
- The bed system belonging to resident #028 exceeded the prescribed dimensional limits in the areas of zone 2 and zone 4;
- The bed system belonging to resident #033 exceeded the prescribed dimensional limits in the areas of zone 2 and zone 4;
- The bed system belonging to resident #034 exceeded the prescribed dimensional limits in the area of zone 4;
- The bed system belonging to resident #036 exceeded the prescribed dimensional limits in the area of zone 2; and,
- The bed system belonging to resident #038 exceeded the prescribed dimensional limits in the area of zone 2.

On the bed system evaluation results document, dated May, 2017, recommended solutions to address bed system failures, including the above-noted failures, are identified.

For bed systems that exceeded the prescribed dimensional limits in the area of zone 2 only (bed systems belonging to resident #036 and resident #038), the recommended solution was to tighten the rails. For bed systems that exceeded the prescribed dimensional limits in the area of zone 4 - including those that failed in both the areas of zone 2 and 4 - (bed systems belonging to resident #'s 028, 033, 034), the recommended solution was to replace the mattress with a specified type of mattress.

On September 8, 2017, Inspector #655 observed the bed systems belonging to resident #'s 028, 033, and 034 (those identified on the bed system evaluation document as requiring a new mattress), while accompanied by Maintenance Staff #120. During this time, it was observed that the mattresses on these bed systems were dated April 1, 2011; June 20, 2014; and, September 9, 2015, respectively. During an interview at the same time, Maintenance Staff #120 reviewed the process in place at the home for the monitoring of mattresses. According to Maintenance Staff #120, the tag on each of the mattresses would have been dated at the time it that it was placed onto the bed system. That is, if the hand-written date on the mattress tag was April, 2011, (as it was for the bed system belonging to resident #028), this would been the date on which that mattress was

placed on that resident's bed system. Based on observations and discussion with Maintenance Staff #120, there was no indication that the recommended solution, a mattress change, had been implemented in order to minimize the risk of entrapment for any of the three above-noted bed systems. According to Maintenance Staff #120, however, RPN #115 would have tracked any mattress changes that did occur. Maintenance Staff #120 was not aware of any other interventions or modifications made to the failed bed systems which required a mattress change as a result of the bed system evaluation process in May, 2017.

During an interview on the same day, Maintenance Staff #120 further indicated to Inspector #655 that for any bed systems that were identified as a result of the bed system evaluation process as requiring the bed rails to be tightened, those bed rails had been tightened, including the bed systems belonging to resident #'s 036 and 038. At the same time, Maintenance Staff #120 indicated to Inspector #655 that he was not sure whether the bed systems were evaluated after the bed rails had been tightened in order to ensure that the action of tightening the bed rails had corrected the zone failures.

During an interview on September 12, 2017, RPN #115 indicated to Inspector #655 that where a bed system was identified as a result of the bed system evaluation process as requiring a new mattress, the mattress had not yet been changed. RPN #115 explained to Inspector #655 that based on the results of the May, 2017, bed system evaluations, approximately 25 new mattresses were required to be purchased (24 based on review of the bed system evaluation results document). RPN #115 indicated to Inspector #655 that she was not aware of any interventions that were implemented in the interim in order to address the risk associated with bed system failures.

During an interview on the same day, RPN #115 also indicated to Inspector #655 that where bed rails were tightened as a result of the bed system evaluation process, those bed systems were not evaluated after the bed rail(s) had been tightened. It was noted by Inspector #655 that, according to the bed system evaluation results document, 12 bed systems were identified to require that the bed rails be tightened. RPN #115 provided Inspector #655 with a hand-written list (titled "Bed Entrapment Audit") of bed systems identified as having loose bed rails contributing to zone failures as a result of the bed system evaluation process. According to RPN #115, if there is a check-mark next to the bed system, it is indicative that the bed system rails had been tightened as recommended. According to the "Bed Entrapment Audit" list, the bed rails had been tightened on all 12 of the identified bed systems. RPN #115 indicated to Inspector #655 that the cone and cylinder tool used for bed system evaluations was not accessible in the

home.

Where bed rails were tightened in order to address bed system failures, there was no process in place to evaluate whether the action resulted in a bed system that would meet the requirements of the prescribed dimensional limits. The bed systems were not evaluated in accordance with prevailing practices after the bed rails were tightened, in order to minimize risk to the resident.

During an interview on September 12, 2017, the Administrator indicated to Inspector #655 that she was not aware of any mattress changes having taken place following the May, 2017, bed system evaluations to date. The Administrator indicated to Inspector #655 that the recommended type of mattress was not available in the home at this time. The Administrator indicated to Inspector #655 that the recommended type of mattress had not yet been ordered. At the same time, Administrator #124 was unable to speak to any interventions that had been implemented in the interim in order to minimize the risk associated with the identified bed system failures.

Upon becoming aware that a total of 36 resident bed systems were evaluated to have one or more failed potential zones of entrapment in May, 2017, the licensee did not take steps to prevent resident entrapment, taking into consideration the failed potential zones of entrapment.

As the non- compliance described above is widespread, and presents the risk of entrapment, a compliance order will be served on the licensee. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to resident #012 related to the use of specialized garment.

On September 12, 2017, Inspector #592 conducted an interview with a family member regarding a concern brought forward in regards to a specialized garment not applied correctly on a resident. (Log #001460-17)

On September 15, 2017, Inspector #592 was told by PSW #134 that resident #012 was wearing a specialized garment on a daily basis but was not assigned today to the resident.

On the same day, resident #012 was observed by Inspector #592 at 1000, 1130 and 1230 hours with no a specialized garment applied. Inspector #592 observed that the specialized garment was hanging on the resident's washroom bar.

On September 15, 2017, PSW #127, who was assigned to resident #012 for the day, indicated that the resident has refused to wear the specialized garment today but that usually staff apply the specialized garment on a daily basis only to one leg as per the instructions left by the nurses.

On September 15, 2017, in an interview with RPN #101, she indicated to the Inspector that resident #012 was no longer wearing the specialized garment. The RPN reviewed the Treatment Administration Records (TARS), in the presence of the Inspector, and could not find any documentation for the use of the specialized garment. The RPN further indicated that when a resident is wearing a specialized garment, it would be identified in the resident's TARS so that a nurse would do a follow-up and sign for the application and the removal of the specialized garment. She further indicated that the resident's written plan of care will also provide directions to the staff members, however, no documentation was found.

A review of resident #012's health care record indicated that resident #012 was admitted with several diagnosis related to cardiac and endocrine disease.

A review of the physician orders was completed by Inspector #592, which identified an order to apply the specialized garment daily, dated in early 2017. In a review of current orders, an order was identified instructing staff to apply the specialized garment to one leg only. A couple of weeks later, the specialized garment was discontinued by the physician.

A review of resident #012's health care record was done by RN #133 who indicated to the Inspector that he was unsure at this current time if resident #012 had to wear the specialized garment as the documentation and instructions were unclear and that he would have to do a follow-up with the physician.

On a later date, RN #133 indicated to the Inspector that a follow-up had been done following the discussion with the Inspector and that an order was found on the Electronic Medication profile requiring resident #012 to wear the specialized garment to both legs on a daily basis which was reinforced with the nursing staff members. RN #133 was unsure why the electronic version did not reflect on the MARS and the TARS.

Staff did not have clear directions related to the application of a specialized garment for resident #012. [s. 6. (1) (c)]

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

Resident #029, #039 and #040 were observed to have side rails in use: resident #029, one quarter rail; resident #039, two assist rails, one in the guard/horizontal position and the other in the assist/vertical position; and resident #040, one long rail.

Resident #029 described to Inspector #148 that he/she uses the horizontal rail to help roll and position him/herself while in bed. The resident described that he/she further uses the vertical rail to transfer him/herself from the wheelchair to bed and from bed to wheelchair. Resident #039 indicated to the Inspector that he/she does not use the rail at all. Resident #040 was not able to answer questions related to the use of the rail. Regular day staff indicated that resident #039 does not use the rail during the day but rather staff assist with bed mobility. During the evening the resident does participate in bed mobility using the side rail. Staff were able to identify that resident #040 and #029 use the side rail for bed mobility and positioning; staff were not in all cases able to identify that the vertical rail for resident #029 was used for transferring.

The Inspector spoke with RPN #115 related to the use of side rails for resident #029, #039 and resident #040. The RPN reported that the use of side rails should be included in the plan of care available to staff at the nursing station and Point of Care. She further noted that the use of bed rails is posted at the head of bed for each resident. She understands that each of these resident use one rail to assist with bed mobility and in addition resident #029 also uses the vertical assist rail to assist in self transfers. It was observed that for each resident there was a posting at the head of bed indicating "1 side rail".

The plan of care was reviewed by the Inspector and RPN #115 for each resident and no plan of care was present to indicate the use or goals of the bed rails, as they relate to the needs and preferences of the three residents identified. [s. 6. (2)]

3. The licensee has failed to ensure that resident #040's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #040 was admitted to the home with multiple diagnoses. According to the most recent Resident Assessment Instrument (RAI) Minimum Data Set (MDS), resident #040, was cognitively impaired.

On August 30, 2017, resident #040's SDM indicated to Inspector #655 that he/she had not been made aware that resident #040 was colonized or infected with bacteria, until he/she had observed the supplies used for contact precautions in resident #040's room.

Inspector #655 reviewed the healthcare record belonging to resident #040.

According to a culture and sensitivity report, resident #040's urine was positive for bacteria when a urine sample was collected in the spring of 2017. According to a second culture and sensitivity report, resident #040's urine was again positive for bacteria when a urine sample was collected one month later.

On review of resident #040's health care record, Inspector #655 was unable to locate any documentation to indicate that resident #040's SDM had been notified of the results of the spring 2017, urine culture and sensitivity report. There was no documentation in the health care record to indicate that resident #040's SDM had been notified that resident #040 was positive for bacteria at any time.

It was noted by the Inspector that there was no indication in resident #040's health care record that any treatments or interventions had been implemented in response to the spring 2017, lab results. According to RPN #115, the hand-written initials on the bottom of the lab report were indicative that the physician had received and reviewed the results. According to RPN #115, if resident #040 was not symptomatic on the day that the results were reviewed, no treatment would have been initiated. RPN #115 indicated to Inspector #655 that resident #040's SDM would have been expected to be notified of the results even if no new medications or other interventions were initiated as a result.

Over the course of the inspection, RN # 113 also reviewed resident #040's health care record with Inspector #655 present. RN #113 was unable to locate any documentation that would indicate that resident #040's SDM was notified of the results of the spring 2017, urine culture and sensitivity report.

On September 5, 2017, DOC #125 indicated to Inspector #655 that resident #040's SDM had not been notified that resident #040 was positive for colonization or infection of bacteria.

Resident #040's SDM was not given an opportunity to fully participate in the development and implementation of resident #040's plan of care when a decision was made not to treat resident #040 for a urinary tract infection that was identified as a result of the spring 2017, urine culture and sensitivity report; or when resident #040's SDM was not made aware that resident #040 was positive for bacteria

During an interview on August 30, 2017, resident #040's SDM indicated to Inspector #655 that he/she had also not been notified that resident #040 was started on a course of antibiotics for the treatment of a urinary tract infection (UTI) until the treatment was already initiated.

Inspector #655 reviewed the health care record belonging to resident #040, and identified two occasions in which resident #040 had been treated for urinary tract infection where resident #040's SDM had not been given an opportunity to fully participate in the development and implementation of that plan of care.

According to the progress notes in resident #040's health care record, resident #040's SDM identified a change in resident #040's status on a specified date. At that time, the SDM communicated that concern to the nursing staff; and, at the same time, requested that a urine sample be collected in order to determine whether resident #040 had a urinary tract infection. According to the progress notes, the urine sample was scheduled to be collected three days following the report from the SDM. According to the progress notes, a registered nurse contacted the physician on the same day, as the report from the SDM, and received an order for prophylactic antibiotics. In a progress note, resident #040's SDM was informed of the order for when a voice message was left for the SDM. The antibiotic was initiated on the same day. There was no indication as to whether the SDM had received or responded to that message based on a record review. In addition, there was no indication that the SDM was contacted a second time before the antibiotics were initiated.

It was noted by the Inspector that both the spring 2017, urine culture and sensitivity report along with the report that was completed one month later, were indicative of urinary tract infections involving the same two organisms.

On review of resident #040's health care record, Inspector #655 noted that another antibiotic had been ordered for resident #040 after the second culture and sensitivity report, for the treatment of a urinary tract infection. On the physicians order, there was no

documentation to indicate that consent for the treatment had been obtained by the resident's SDM. There was also no documentation in the progress notes to indicate that resident #040's SDM had been involved in the decision to treat resident #040 with the antibiotic.

During an interview on September 1, 2017, RN #113 indicated to Inspector #655 that the nurse is responsible for notifying the resident and/or resident's SDM where there is a change in the resident's status or when an order is received for a new medication. According to RN #113, when the SDM is notified of a change in a medication order, it is normally documented on the physicians order sheet or in the progress notes.

During the same interview on September 1, 2017, RN #113 indicated to Inspector #655 that it would be her practice to wait until the SDM has specifically agreed to a treatment before initiating it; rather than initiating the treatment after leaving a voice message. At the same time, RN #113 noted that there was no indication that the SDM was made aware of the new order for an antibiotic.

During an interview on September 5, 2017, DOC #125 confirmed that resident #040's SDM is expected to be notified by a Registered Nurse whenever there is a medication change. At the same time, DOC #125 indicated to Inspector #655 that it would be insufficient to notify resident #040's SDM of a medication change in a voice message; and that a new medication should not be administered until the SDM has agreed to the change. According to DOC #125, if resident #040's SDM had returned the call when a message was left related to a medication change, it would be documented in a progress note.

As a result of the inspection, there was no indication that resident #040's SDM had been given an opportunity to participate in the development and implementation of resident #040's plan of care when, on two occasions resident #040 was prescribed antibiotics for the treatment of a urinary tract infection. [s. 6. (5)]

4. The licensee has failed to ensure that resident #039, or resident #039's SDM, was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

During an interview on August 30, 2017, resident #039 indicated to Inspector #655 that he/she is not given an opportunity to participate fully in the development and

implementation of his/her plan of care. Specifically, resident #039 indicated to Inspector #655 that changes in treatments, such as medications, are not discussed with him/her. At the same time, resident #039 indicated to Inspector #655 that he/she does not believe a family member is necessarily involved in his/her care decisions either.

Inspector #655 reviewed the health care record belonging to resident #039, including recent physician's orders. Inspector #655 noted two orders written within the same month, which referred to medication changes. There was no indication on the physician's order as to whether resident #039 or an SDM had been notified or consented to the medication change.

During an interview on September 15, 2017, RPN # 133 indicated to Inspector #655 that in the case of resident #039, it is an SDM who is notified and involved in decisions related to medication changes. RPN #133 reviewed the physician's order described above, with Inspector #655 present. RPN #133 indicated to Inspector #655 that where there is no indication that the medication change had been discussed with the SDM in the physician's orders, it should be documented in a progress note. RPN #133 reviewed resident #039's progress notes and was unable to locate any documentation to indicate that resident #039's SDM had been notified of the medication change.

Inspector #655 also reviewed the progress notes for the identified month and was also unable to locate any documentation to indicate that resident #039 or a SDM had been notified of the medication change that took place.
Over the course of the Inspection, RN #113 and DOC #125 also indicated to Inspector #655 that where a SDM is involved in a decision related to a mediation change, it is documented in the progress notes.

There was no indication that resident #039 or resident #039's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care when an order was received for a new medication.

The licensee has failed to ensure that resident #040 and resident #039's substitute decision-maker's (SDM's) were given an opportunity to participate fully in the development and implementation of each of the resident's plans of care. [s. 6. (5)]

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

Resident #024 was admitted with several diagnoses.

A review of resident #024's health care record was completed by Inspector #592 which indicated that according to the current plan of care under nutrition status, resident #024 was to be provided with dietary interventions at meal times including regular diet and a cut-up texture. The plan of care also indicated that resident #024 was to be provided with a portion of home shake when less than 50% of meal was consumed to prevent further weight loss.

On a specified date, Inspector #592 conducted a dining observation at breakfast time. The Inspector observed resident #024 being supervised by a PSW, while sitting at the dining table. The resident was plated two pieces of toast, both untouched on the resident's plate as well as half a bowl of cereal, the food items were observed being served as regular texture. PSW #130, who was supervising the table of resident #024, indicated to the Inspector that the resident was done with his/her breakfast and that usually the resident will eat more at lunch time. The PSW further indicated that the total food intake was documented on the food and fluid intake sheet and today's breakfast for the resident would be recorded at 25%. PSW #130 further indicated that there was no other specific interventions for resident #024 when the meal was not completed other than distributing the morning collation later on. PSW #130 further indicated that she refers to the kitchen board for the resident's texture and that the resident was to be provided with a cut-up texture.

Inspector #592 observed the kitchen board after the interview with the PSW and noted that there was a note indicating to provide resident #024 with a trial puree texture.

In an interview with DA #132, she indicated to the Inspector that the home shakes were prepared by the kitchen staff and were kept in the kitchen fridge which the PSWs would ask for, when needed. DA #132 further indicated that she was not aware that resident #024 was to be provided with a home shake as the resident was not on her list for regular home shake. She further indicated that she had worked September 4, 5, 7 and 8, 2017, and does not recall any PSW asking for a home shake for resident #024. When Inspector #592 inquired about the resident's texture, the DA indicated that the resident was on a cut-up texture in the past, but had just found out, after the breakfast was served, that the resident was put on a trial for puree texture, therefore, the resident was not provided with the appropriate texture at the breakfast meal service.

A review of resident #024's food and fluid intake was completed for the period of September 5 to September 10, 2017.

The documentation indicated that the resident had consumed less than 50%, of at least one meal, on September 6, 7, 8, 9 and 10.

In an interview with the home's RD, she indicated to the Inspector that resident #024 is to be provided with a portion of the home shake when less than 50% of meal was consumed to prevent further weight loss. She further indicated that there was no documentation to support that the home shake was provided to the resident other than looking at the resident's food intake. Inspector #592 observed with the RD the food and fluid intake for resident #024 from September 5 to September 10, 2017. The RD indicated that the resident should have been provided with a home shake on the days noted above but was unable to provide any documentation that the home shake had been given to the resident. The RD also noted in the presence of the Inspector that there was a note on the communication sheet and on the kitchen board indicating a change of the resident's diet from cut-up texture to puree texture until a dietary assessment was done.

As such, resident #024's care set out as it related to nutritional care was was not provided as specified in their plan of care. [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #039 as specified in the plan.

Inspector #655 reviewed the health care record belonging to resident #039. According to the health care record, resident #039 is at risk for skin breakdown and has a history of pressure ulcers.

In resident #039's current plan of care includes several interventions related to skin care, including nutritional interventions. According to resident #039's care plan, resident #039 is to receive a double portion of protein at meal times.

During an interview on September 15, 2017, PSW #108 identified resident #039 as being at risk for skin breakdown; however, PSW #108 was not aware of any related nutritional interventions in place.

During an interview on the same day, PSW #112 was also unable to speak to any nutritional interventions in place for resident #039. PSW #112 indicated to Inspector #655 that if resident #039 was on any nutritional interventions related to the resident's risk for skin breakdown, this would be documented on a list that is kept by dietary staff in the kitchen.

During an interview on September 15, 2017, Dietary Aide #139 was observed to review the list that is kept in the kitchen. Dietary Aide #139 was able to identify the diet and texture needs of the resident, but indicated to Inspector #655 that resident #039 did not have any other nutritional interventions in place. Dietary Aide #139 specifically indicated to Inspector #655 that resident #039 was not receiving double portion protein at meal times. On the same day, Dietary Aide #139 indicated to Inspector #655 that resident #039 had been receiving double portion protein in the past for the purpose of wound healing; but that it had since been discontinued.

Inspector #655 reviewed resident #039's progress notes. According to a progress note on a specified date, resident #039 was to receive a double portion of meat at meals to help with healthy skin maintenance. There was no indication on review of resident #039's health care record that the double protein intervention had been discontinued.

During an interview on September 18, 2017, the home's RD indicated to Inspector #655 that the nutritional intervention, double portion of protein at meal times, remains in place for resident #039 as a preventative measure related to the resident's risk for skin break down. The RD explained, for example, that when the regular serving includes a three ounce piece of meat with a meal, resident #039 should receive two, three ounce pieces of meat.

On the same day, the Food Services Supervisor also confirmed that resident #039 is to receive a double portion of protein with all meals; and that this information is expected to be identified on the dietary list used by staff in the kitchen.

The licensee has failed to ensure that the care set out in the plan of care is provided to resident #039 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out by the plan of care, related to nutrition and hydration, is provided to resident #024 and #039 as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

In accordance with O. Regulation 79/10, s. 45(1), for homes with a licensed bed capacity of 64 beds or fewer, a registered nurse who works at the home pursuant to a contract or agreement between the nurse and the licensee and who is a member of the regular nursing staff may be used; in the case of an emergency where the back-up plan referred to in clause 31(3)(d) of O. Regulation 79/10 fails to ensure that the requirement under subsection 8(3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone or a registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone.

As defined by O. Regulation 79/10, section 45(2), emergency means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

Further, O. Regulation 79/10 section 31(3) (d) requires the licensee to have a written staffing plan that includes a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8. (3) of the Act, cannot come to work.

Sandfield Place is a 53 bed long-term care facility located in Cornwall.

Two anonymous complaints were submitted to the Director related to concerns that a registered nurse was not present in the home at all times. One of the complaints included dates from June 2017. (Logs 013592-17 and 019446-17)

Inspector #148 reviewed the registered nurse (RN) staffing roster from June 4 to September 9, 2017. Fourteen instances were found whereby the staffing roaster did not support that an RN was on duty and present in the home at all times. The Inspector spoke with the home's Director of Care who reported that RN staffing has been challenging specifically since the spring of 2017. She noted that two RN staff members retired in April/May 2017 and another went on a sick leave, and later left the home, in June 2017. The DOC reported that the home is in the process of hiring and training RNs to fill these positions, noting at least three RNs who have been added to the roster and two others that have been hired but are awaiting their registration with the Collage of Nurses of Ontario. When asked about the licensee's back up plan, the DOC indicated that when an RN is not able to come for a shift, the home will attempt to replace the staff person by first using the call in list for RN staff. If no RN is found, then the home will begin to call RPNs to replace the RN shift. The DOC described that as Sandfield is a smaller home, that the home may use RPNs to fill the RN shift vacancy, with herself available by phone. She further noted, that she will also fill in the RN shift herself, as needed. Writer described the requirements for an RN to be on duty and present in the home at all times and the application of section 45(1) as it relates to home's with fewer than 64 beds. The DOC indicated that when the home cannot fill the RN shift, she had understood that as a smaller home, an RPN with back up of an RN by phone was appropriate. When questioned by the Inspector if any of the instances, whereby an RN was not present in the home between June 4th and September 9th 2017 were related to emergencies, it was determined that there were no unforeseen situations of a serious

nature that prevented the registered nurse from getting to the home..

In a similar discussion with the home's Administrator, the Administrator described that when an RN is not able to come for a shift and the back up plan fails to fill that shift that this is considered an emergency and therefore the licensee is able to use an RPN to fill the shift with an appropriate RN available by phone.

The RN staffing roster was reviewed and confirmed with both the home's DOC and Administrator. With consideration to the presence of the DOC or Administrator, who are both registered nurses, it was demonstrated that on the following days and times an RN was not on duty and present in the home:

Sunday, June 4, 2017, from 6am-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Tuesday, June 6, 2017, from 4pm-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Thursday, June 8, 2017, from 4pm-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Saturday, June 10, 2017, 6am-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Sunday, June 11, 2017, from 6am-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Friday, June 16, 2017, from 6am-8am
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Monday, June 19, 2017, from 4pm-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Saturday, July 1, 2017, 6am-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Monday, July 24, 2017, from 4pm-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Thursday, August 3, 2017, from 4pm-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Monday, Statutory Holiday, August 7, 2017, from 6am-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Sunday, August 20, 2017, from 6am-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Friday, August 25, 2017, from 4pm-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

Monday, Statutory Holiday, September 4, 2017, from 6am-6pm
An RPN was schedule to replace the RN shift with DOC/Administrator on call

In addition, documentation and interview with the home's DOC does not support that the back-up plan, including calling the available pool of RNs, was implemented on June 19, July 1 and 24, August 3 and 7 and September 4; dates identified above whereby there was no RN on duty for a period of time. [s. 8. (3)]

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 at least one registered nurse is on duty and present in the home at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The most recent MDS assessment, indicates that resident #013 experiences moderate pain daily. In the previous MDS assessment, the resident is coded to have no pain, whereas the assessment previous to this, indicates mild daily pain.

Inspector #148 spoke with two PSW staff, two RN staff and one RPN staff member. It was reported to the Inspector that the resident experiences pain daily, primarily when transferring to a seated or standing position. The resident will exhibit pain by facial grimace, holding of his/her knees or hip, resisting care and other responsive behaviours. Point of Care flow sheets support that the resident experiences pain daily. Progress notes from both the home's nursing staff and mental outreach program note the continued concern of pain management.

The Inspector reviewed the resident's health care record and noted that within the last two months the residents medication has been adjusted; including dosage and administration times. RNs #100 and #126 reported that the changes were to assist in improving pain and responsive behaviours during times of care and the changes have been noted to have some positive effect. In addition, the resident's pain was further investigated to rule out any source of injury.

In review of the resident's health care record, despite the modifications to pain interventions, the resident's pain has not been relieved. At the time of the resident's admission to the home, a Pain Assessment tool was initiated, however, remains incomplete. As of September 6, 2017, the resident's ongoing pain as not been reassessed using a clinically appropriate assessment instrument specifically designed for this purpose. When interviewed by the inspector the home's DOC reported that the Pain Assessment tool available is to be completed by registered nursing staff on admission and when there is a change in pain, potentially it may need to be completed quarterly if there is ongoing pain. [s. 52. (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 pain of resident #013 is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to consult regularly with the Family Council, and in any case to consult with the Family Council at least every three months.

During an interview on August 30, 2017, Family Council Co-Chair #122 indicated to Inspector #655 that the licensee did not consult regularly with the Family Council; nor did the licensee consult with the Family Council at least every three months.

During an interview on September 6, 2017, the home's Administrator indicated to Inspector #655 that any consultation with the Family Council would be done when/if Family Council brings a concern forward or otherwise approaches her or the home's DOC. The Administrator indicated to Inspector #655 that she is not often approached by Family Council; and explained the much of the consultation that occurs would be done by the DOC.

During an interview on September 6, 2017, the DOC indicated to Inspector #655 that there was no formal process in place whereby the licensee would consult with the Family Council regularly or at least every 3 months. The DOC indicated to Inspector #655 that the licensee would respond if/when Family Council brought concerns forward or invited a representative of the licensee to attend a Family Council meeting. During the same interview, the DOC indicated to Inspector #655 that she was not aware of the licensees' duty to consult regularly with the Family Council, or at least every three months, as per s. 67 of the LTCHA (2007).

The licensee has failed to consult regularly with the Family Council, and in any case to consult with the Family Council at least every three months. [s. 67.]

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 licensee consults regularly with the Family Council, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview on August 30, 2017, Family Council Co-Chair #122 indicated to Inspector #655 that the licensee did not seek the advice of the Family Council in developing or in carrying out the satisfaction survey; and did not seek the advice of the Family Council in acting on its results. Family Council Co-Chair #122 further indicated to Inspector #655 that the Family Council was disappointed that they had not been asked about the satisfaction survey, noting the satisfaction survey that was most recently distributed (in December, 2016) was the same survey that was distributed for the past several years. Family Council Co-Chair #122 described the satisfaction survey as being difficult to complete with insufficient response choices; and identified concerns related to the methods used to carry out the survey. During the same interview, Family Council Co-Chair #122 indicated to Inspector #655 that the Family Council was provided with a written copy of the satisfaction survey results only when it was requested by the Family Council; and, the results were not provided for the purpose of seeking the advice of the council in acting on those results.

Based on a record review, the satisfaction survey was distributed on December 23, 2016; while the Family Council was established in October, 2016. According to the meeting minutes, the Family Council inquired about the availability of the satisfaction survey for review in November, 2016.

During an interview on September 6, 2017, the home's Administrator indicated to Inspector #655 that she did not recall if Family Council had the opportunity to review or offer advice with regards to the development or carrying out of the satisfaction survey before it went out in December, 2016. The Administrator further indicated to Inspector #655 that the advice of the Family Council with regards to acting on the results of the satisfaction survey would have been sought out if there was an outstanding issue for which a need to consult the Family Council had been identified; or, if the Family Council

had chosen to communicate any input in the Family Council meeting minutes after they had reviewed the satisfaction survey results. The Administrator indicated to Inspector #655 that there was no indication that follow-up was requested in the Family Council meeting minutes; and that there had been no input sought out from the Family Council with regards to acting on the most recent satisfaction survey results.

The licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

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 licensee seeks the advice of the Family Council in development and carrying out the satisfaction survey and in acting on its results, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart

that is secure and locked.

On August 29, 2017, Inspector #566 observed the following in a shared resident bathroom:

1) One jar of prescription cream on the counter beside the sink
2) One jar of prescription cream on the other side of the sink

On August 30, 2017, Inspector #566 observed the following in a shared resident bedroom:

1) One jar of prescription cream on a resident's bed side table.

On August 30 and September 05, 2017, Inspector #592 observed the same prescribed cream in the same rooms as well as the same prescribed cream in two other shared resident bedrooms.

A review of health care records for the identified resident's residing in the bedrooms described above showed no indication that the prescribed creams were to be self-administered.

On August 30, 2017, in an interview with RN #100, she indicated to Inspector #592 that the prescribed topical creams were to be left in the resident's bathroom for the PSWs to apply to the residents until the treatment was completed.

On September 5, 2017, in an interview with RPN #115, she indicated to Inspector #592 that prescribed topical creams were to be kept in the resident's bin on the upper shelf in the bathroom for the PSWs to use; to keep the creams from being accessible to residents. When the Inspector inquired about the prescribed topical creams observed in two of the rooms, PSW #114 who was nearby during the conversation indicated to the Inspector that one of the residents mentioned above, was requesting to have the topical cream beside the sink in order to remind PSWs to apply it. RPN #115 indicated to the Inspector that the prescribed topical creams were to be put in the resident's bin regardless of the resident's request in order to keep the topical cream out of reach from residents.

On September 5, 2017, in an interview with the DOC, she indicated to Inspector #592 that all prescribed topical creams should be kept in the resident's personal bins in the

bathroom which is located on the upper shelf, unreachable to the residents. She further indicated that she has noticed that topical creams were left at some resident's bed side and on the counter in the resident's bathroom accessible to residents, which was not the home's current practice. The DOC confirmed that none of the residents above were authorized for self-administration of topical creams nor were their authorized to keep their prescribed creams at their bedside. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

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

During the initial tour of the home Inspector #592 recorded observations that five resident rooms were identified with a table outside of the room with various personal protective equipment (PPE) including but not limited to gloves, gowns and masks. The inspector observed there to be no indication of what precautions were in place for the given resident rooms.

On September 1, 2017, Inspector #148 conducted a follow up observation and noted the following resident bedrooms with PPE available for use: room #5, gloves, gowns; room

#16, gloves, gowns, masks, disinfectant wipes; room #21, gloves, gowns, masks, disinfectant wipes; room #22, gloves, gowns, masks; room #23, gloves; and room #25, gloves, gowns. With the exception of room #16, there was no notification of what precautions were in place for each of the identified rooms. The Inspector noted room #16 and #25 are private accommodation.

On September 1, 2017, Inspector #148 spoke with PSW #109 regarding the PPE located at the above identified rooms. PSW #109 indicated that the PPE are likely from the outbreak a couple of months ago and have not yet been removed. When asked, she reported that if she were to provide care in these rooms that she would not need to use the PPE. The Inspector then spoke with PSW #111, and reviewed the rooms on Ivy Lane hallway. The PSW was not aware of the reason for the PPE outside of each room, but indicated that she would use the PPE available at the door for an identified resident in room #21, for an identified resident in room #22 and an identified resident in room #23. The Inspector spoke with PSW #108 who indicated that she would use the PPE available at the door for a resident in that room with some kind of infection, she was not sure what infection but noted that there is a list maintained at the nursing station that she could check. When asked if she was aware of who in shared rooms #21, #22 and #23 would require the use of PPE she identified a resident for room #21 and #22 but noted she would need to check the list to identify the resident for room #23. The Inspector then spoke with PSW #112 regarding shared resident room #5, when asked who the PPE gear was to be used for in this room, the PSW reported that it must be for an identified resident as the co-resident is not in the room and the identified resident was in bed with a basin. The Inspector spoke with PSW #106 who indicated that the resident in room #16 requires gloves, mask and gown, an identified resident in room #21 needs use of glove and gown, an identified resident in room #22 needs gloves only, an identified resident in room #23 need gloves only, an identified resident in room #25 needs gloves and gown.

The Inspector reviewed the ARO's (Antibiotic Resistant Organism) document, available at the nursing station, which listed eight residents in eight different rooms with either MRSA, VRE or ESBL. The current plans of care for each of the identified residents also indicated the presence of an ARO. The Inspector noted that three of the residents listed on the ARO, did not have any PPE located at the point of care (or outside of the bedroom door), nor did the rooms contain any notification for the use of precautions or PPE. When staff were specifically asked about rooms those three bedrooms/residents, staff were not aware of any need for the use of PPE in these rooms. Furthermore, the Inspector noted that one of these identified residents, who was identified as requiring use of PPE by staff interviews above, was not identified on the ARO list. The plan of care for that same

resident indicates MRSA of unknown origin. The plans of care were reviewed for all residents identified above, whereby the ARO was confirmed and interventions included contact precautions.

Inspector #148 spoke with RN #113 to review the ARO document. RN #113 indicated that for MRSA, VRE and ESBL she would direct staff to use contact precautions including gloves and gown, she would not expect the use of masks. The Inspector identified the three residents who were listed on the ARO document but where there was no PPE available at the point of care. The RN indicated she would follow up with this.

On the morning of September 5, 2017, Inspector #148 observed the three bedrooms that had been identified on the ARO list but where there was no PPE available in earlier observations and noted that PPE had been made available at the entry of the resident bedrooms, including gloves and gown. Additional signage had also been posted at the entry to four resident bedrooms indicating isolation and use of gloves, gown and mask.

In review of the home's infection prevention and control program the following policies were reviewed, #10.2, #10.4 and #10.5 which relate to MRSA, VRE and ESBL, respectively, along with a resource binder located at the nursing station for AROs. The policies indicated that signage at the entrance to the resident's room will be posted describing the required contact precautions, defined as the use of gloves and gown. In addition, within a resource binder at the nursing station, there are documents to direct staff to use contact precautions for multi-drug resistant organisms.

On September 5, 2017, Inspector #148 spoke with the home's DOC regarding the expectations of the home's infection prevention and control program. The DOC reported that in the cases of MRSA, VRE and ESBL, residents would be placed on contact precautions which include the use of gloves and gown, only. She further indicated that PPE should be readily available and signage posted at the entry of the resident's room to indicate the precautions that are to be implemented. She clarified that the only resident on isolation, due to respiratory symptoms, signage on other rooms indicating isolation was not correct. In response to the observations and staff interviews collected, the DOC noted that communication to staff of those resident's requiring the use of contact precautions was lacking, along with staff understanding of contact precautions and the PPE to be used.

Staff did not participate in the implementation of the licensee's infection prevention and control program in that, staff were not in all cases aware of the residents in the home to

which PPE was to be used, contact precautions were not being adhered to for all residents with MRSA, VRE and ESBL as described by the licensee's program nor was the appropriate signage used for all residents with MRSA, VRE and ESBL as described by the licensee's program. [s. 229. (4)]

2. During an interview on August 30, 2017, resident #040's substitute decision maker (SDM) indicated to Inspector #655 that he/she had not been made aware that resident #040 was colonized or infected with bacteria.

Inspector #655 reviewed the health care record belonging to resident #040.

According to a culture and sensitivity report, resident #040's urine was positive for bacteria when a urine sample was collected in the spring of 2017. According to a second culture and sensitivity report, collected one month later, resident #040's urine was again positive for bacteria.

Inspector #655 reviewed resident #040's current care plan. Based on the documentation in the care plan, resident #040's care plan was updated to include resident #040's status and requirements for infection prevention and control including contact precautions, implemented seven weeks after resident #040 was first identified as being positive for bacteria.

Inspector #655 reviewed the policy titled "Antibiotic Resistant Organisms" (10.0), in the section of the policy titled "Management of an ESBL E. Coli", it is indicated that when a resident is identified as being colonized/positive for ESBL E. Coli, precautions are to be implemented. In the section titled "Precautions to be used for ESBL colonized Residents", those precautions are identified, including (but not limited to):
- Signage on the resident's door advising all persons to check in at the nursing station before entering the room,
- The use of gloves by staff when providing all direct personal care or cleaning the resident's environment,
- The use of gloves by visitors,
- Documentation of the precautions/barriers to be used in the resident's care plan; and,
- Requirements for the cleaning of ESBL positive resident environments are outlined (i.e. procedures for cleaning toilets).

Over the course of the inspection, the DOC reviewed the process by which a resident's ESBL status is communicated and through which the necessary infection prevention and

control precautions are to be implemented. According to the DOC, the registered nurse would be responsible for documenting a resident's ESBL positive status as soon as it is identified in the communication book, the resident's care plan, and on a "master list". The registered nurse would also be responsible for ensuring that other departments, such as housekeeping, are made aware; and for implementing the required contact precautions.

During an interview on September 1, 2017, PSW #108 indicated to Inspector #655 that there were contact precautions in place when doing personal care for resident #040. PSW #108, however, was unsure why or for how long the contact precautions were in place.

According to the ARO list, resident #040 was identified as being positive for bacteria after the second culture and sensitivity report.
On the same day, RPN #118 provided Inspector #655 with the communication book, also used by registered nursing staff to communicate the presence of an infection or ARO in a resident. On review of the communication book, there was no record of resident #040's status after the culture and sensitivity report collected in the spring of 2017.

During interviews on September 8, 2017, Housekeeping staff #140 and #141, indicated to Inspector #655 that contact precautions were put in place for resident #040 the week prior to the interview (the week of August 28, 2017); however, both were unsure if there were any contact precautions implemented prior to that time.

During an interview, RN #113 noted that there was no signage on resident #040's door as of September 1, 2017, that would be indicative of the need to use contact precautions when providing care to resident #040. RN #113 indicated to Inspector #655 that for this reason, she did not know that any additional infection prevention and control precautions were in place for resident #040 at the time of the inspection.

During an interview on September 6, 2017, the DOC confirmed that the date at which the contact precautions were implemented for resident #040 would be identified on the master list (the "ARO" list) - in this case, was after the second culture and sensitivity report. DOC #125 clarified that between spring 2017 and second culture and sensitivity report, there were no additional infection prevention and control precautions put in place to address the risk.

Over the course of the inspection, no information or documentation was provided to the Inspector that would be indicative that resident #040 had been on contact precautions

prior to the second urine culture and sensitivity report; and, the necessary infection prevention and control precautions were not included in the residents plan of care until August 10, 2017.

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 participate in the implementation of the infection prevention and control program, specifically as it relates to the use of precautions,, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker (SDM), if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences.

In accordance with section 27 of Regulation 79/10, the licensee shall ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually thereafter to discuss the plan of care and any other matters of importance to the resident and his or her SDM and a record is kept of the date, participants and results of the conference.

During interviews with residents #009, #029 and #039, it was reported that they feel they are not involved in decisions about the care they receive. The residents provided examples whereby they did not feel involved in daily care decisions and lacked participation in their annual care conferences.

The most recent care conferences for residents #009, #029 and #039, were held in 2017. In each of the records it was noted that family members were invited, however, there was no indication that the resident had been invited or was in attendance. The Inspector spoke with the home's RAI Coordinator who organizes the care conferences. The RAI Coordinator indicated that the SDM's of each resident is invited and encouraged to attend the care conference and that the participation of the resident is at the discretion of the SDM. The Inspector confirmed with the RAI Coordinator that there is no attempt by the licensee to approach the resident and invite him or her to the care conferences. In this way the licensee has failed to ensure that the resident is given an opportunity to participate fully in the care conference. [s. 27. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During observations of resident shared bathrooms, specifically rooms #6, #17, #18, #21, #23 and #24, it was noted that several used personal items were not labelled and left on the shared bathroom counters including; toothbrushes, denture cups, razors, deodorants, hair brushes and combs.

Inspector #148 interviewed PSW staff members responsible for resident care. PSW #105 and PSW #104 indicated that the items should be labelled or placed in the basket labelled with the resident's name; items should not be left out on the shared counter as it was not always possible to identify which item belonged to which resident. PSW #106 reported that in one of the identified rooms the residents are fairly independent and know which items are theirs, but noted they should likely still be labelled. PSW #105 further reported that it is not the PSWs who label personal items but rather the registered nursing staff or DOC. When asked, PSW #106 was not sure who's responsibility it was to label resident personal items and suggested that it may be the RAI Coordinator who does this task.

The Inspector spoke with the home's DOC who indicated that it is the expectation that all personal items be individually labelled for a resident. This labeling is either done with a printed label or by writing the resident name on the item using a marker. The DOC reported that it is both the PSW and registered nursing staff who are responsible to ensure that all personal items are labelled. [s. 37. (1) (a)]

WN #11: 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 :

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.

A review of resident #022's health care record was completed by Inspector #592 which indicated that on an identified date a wound assessment was completed to a specific area of the body as it relates to a pressure ulcer stage III. The next skin assessment was dated two weeks later, and the next conducted thirteen days later.

The Treatment Administration Report (TARS) on a specific date, direct staff in the cleaning and treatment of the wound, with dressing changed every two days.

On September 6, 2017, RPN #115, indicated to Inspector #592 that resident #022 was still exhibiting altered skin integrity to the identified area of the body and continued to require treatments. She further told Inspector #592 that the area was healing well and was almost closed. She further indicated that a weekly skin assessment was performed for each resident exhibiting altered skin integrity including pressure ulcers using the "Bates Jensen" wound assessment located in their electronic software. The RPN #115 indicated that she was the resource person for the skin care program and that she was responsible to perform the weekly skin assessment for all the residents.

Upon reviewing resident's #022 health care records, RPN #115, indicated to Inspector #592 that she was not able to find any documentation for the weekly skin assessment for resident #022, for the time period noted. She further indicated to Inspector #592 that resident #022 should have had a weekly skin assessment completed as part of the home's wound care program. [s. 50. (2) (b) (iv)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Family Council has advised the licensee of concerns or recommendations, the licensee, within 10 days of receiving the advice, responded to the Family Council in writing.

Inspector #655 interviewed the Co-Chairs (#122 and #123) of Family Council on August 30, 2017.

During the interview on August 30, 2017, Family Council Co-Chair #122 indicated to Inspector #655 that the licensee did not respond in writing within 10 days of receiving advice from the Family Council when the Family Council had advised the licensee of concerns or recommendations. Family Council Co-Chair #122 was able to provide two specific examples:

i. According to Family Council Co-Chair #122, the Family Council held a meeting on November 21, 2016. At the time of the November, 2016, meeting, the Family Council identified several concerns related to the operation of the home; among them were: concerns related to snow removal, food quality, and staffing shortages. Family Council Co-Chair #122 indicated to Inspector #655 that these concerns were verbally reported to Administrator #124 after the meeting. According to Family Council Co-Chair #122, Administrator #124 responded in writing to Family Council in a letter dated December 5, 2016 – fourteen days later.

ii. According to Family Council Co-Chair #122, the Family Council held a meeting on January 30, 2017. At the time of the January, 2017, meeting, the Family Council identified three concerns, including a safety concern related to the storage of idle resident equipment (i.e. walkers, wheelchairs) in hallways. According to Family Council Co-Chair #122, the Family Council had provided Administrator #124 with a written letter on February 1, 2017, in which these three concerns had been identified. Family Co-Chair #122 indicated to Inspector #655 that by the time of the next Family Council

meeting on March 13, 2017, the Family Council had yet to receive a written response from Administrator #124 with regards to those concerns, the concerns were re-submitted to Administrator #124 in writing on March 14, 2017. Family Council Co-Chair #122 indicated to Inspector #655 that the written response from Administrator #124 was not received by the Family Council until March 20, 2017- 37 days after the first letter was provided to Administrator #124.

Inspector #655 reviewed selected documents from the Family Council, provided to the Inspector by the Family Council Co-Chairs during the interview on August 30, 2017, including the above-described written letters addressed to Administrator #124 on February 1 and March 14, 2017, respectively. Inspector #655 also reviewed the written response from Administrator #124 with regards to those concerns. The written response letter from Administrator #124 was addressed to the Family Council, and was dated February 21, 2017 – twenty days after the Family Council first brought the concerns forward to Administrator #124 on February 1, 2017. On the written response letter from the Administrator, there was a hand-written note indicating that the letter was received by the Family Council on March 10, 2017. According to Co-Chair #122, it was DOC #125 who gave the Administrator's response letter to the Family Council on March 10, 2017.

During an interview on September 6, 2017, Administrator #124 was unable to recall whether she had responded in writing within 10 days of receiving the advice of Family Council when on December 5, 2016, she had responded in writing to the concerns that were identified by Family Council on November 21, 2016. At the same time, Administrator #124 indicated to Inspector #655 that there was at least one case in which Family Council had not received her written response within 10 days, most likely in March, 2017, when her response (which was dated February 21, 2017 – fourteen days after Family Council provided the advice) had been misfiled and was subsequently provided to the Family Council by DOC #125. During an interview on September 6, 2017, DOC #125 indicated the same. During the same interview, DOC #125 indicated to Inspector #655 that she was not aware of a requirement to respond in writing within 10 days of receiving advice from Family Council.

The licensee has failed to ensure that when the Family Council has advised the licensee of concerns or recommendations, the licensee, within 10 days of receiving the advice, responded to the Family Council in writing. [s. 60. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the recreation and social activities program includes opportunities for resident and family input into the development and scheduling of recreation and social activities.

In accordance with s.65(2) of Regulation 79/10, the recreation and social activities program is to include a schedule of recreation and social activities that are offered during the days, evenings and weekends and that are of a frequency and type to benefit all residents of the home and reflect their interests.

During interviews with 20 residents, 12 residents indicated negative responses related to the recreation and social activities including two responses where by the activities do not meet their interests, eight responses to which the residents reported there to be no activities on the weekends and eight responses to which the resident reported there to be

no activities in the evenings.
Inspector #148 reviewed the home's activity calendar available for residents which describes that bingo is offered every Saturday and a tea social is offered every Sunday. In addition, there is one evening a month whereby an evening program is offered.

The Inspector spoke with the home's Activity Supervisor who indicated that bingo and the tea social have been in place for a long time. She noted that there are student hired for these weekend activities and the bingo and tea are activities that are simple for the students to implement. She acknowledged that this activity does not likely meet the interests of all residents. In discussion of the evening activity, she noted that there are no activity staff available at the nursing home for evening programming. A staff member from the affiliated retirement home is made available once a month and this staff person implements the evening program each month. She noted the staffing level is limited and they would need to reduce day time programs in order to facilitate evening programs.

The Inspector reviewed both the home's most recent satisfaction survey and the last three months of resident council meeting minutes. It was noted that the activity calendar is presented to the residents and the previous month's reviewed at each resident council meeting, however, development and scheduling including the frequency and type of activities related to evenings and weekends is not discussed. The satisfaction survey includes two questions pertaining to the encouragement of attending activities and if the residents are sufficiently informed of activities occurring in the home.

The licensee could not demonstrate when the residents or families were given an opportunity to offer input into the development and scheduling of the recreation and social activities. Specifically, there was no demonstration that the frequency and type of activities offered on the evenings and weekends were discussed with residents or family. [s. 65. (2) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of resident #017's health care record was completed by Inspector #592 which indicated that a wound assessment was completed on a specified date, which indicated a stage one pressure ulcer to a specified area of the body. The wound assessment indicated that the treatment was to include the application of lotion daily.

The Treatment Administration Report (TARS) for September 2017 indicated that the current treatment was to apply barrier cream twice a day to the specified area of the body.

On September 7, 2017, Inspector #592 observed at the bed side of resident #017, a barrier cream with a hand written label indicating apply twice daily to a specified area of the body .

On September 7, 2017, in an interview with PSW #104, the full time PSW indicated to Inspector #592 that resident #017 has chronic skin alteration to an identified area of the body, therefore the skin is monitored closely by PSWs while providing care to the resident. PSW #104 further indicated that barrier cream was applied as needed to the identified area of the body if there was a skin breakdown but if the skin was intact no cream was applied other than regular cleaning of the area.

On September 7, 2017, Inspector #592 spoke with PSW #111 who was assigned to resident #017 for the day. PSW #111 indicated to the Inspector that the resident has skin alteration on and off to the identified area of the body, therefore, barrier cream was applied as needed. PSW #111 indicated that she did not apply any cream this morning to the resident as there was no opening to the area, however, she would let know the nurse if she would use it.

On September 7, 2017, in an interview with RPN #115 who is the resource person for the skin care program, indicated to the Inspector that resident #017 has altered skin integrity due to friction/shearing to the identified area of the body, therefore, the area was to be monitored on a daily basis using the TARS. She further indicated that at this current time the treatment was for the PSW's to apply barrier cream twice a day to the area to keep the skin intact as per the physician orders.

As demonstrated above, resident #017 topical cream was not applied in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 9th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148), MELANIE SARRAZIN (592), MICHELLE EDWARDS (655)
Inspection No. / No de l'inspection :	2017_617148_0027
Log No. / No de registre :	014857-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 24, 2017
Licensee / Titulaire de permis :	458422 ONTARIO LIMITED 220 EMMA STREET, CORNWALL, ON, K6J-5V8
LTC Home / Foyer de SLD :	SANDFIELD PLACE 220 EMMA STREET, CORNWALL, ON, K6J-5V8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephanie Kinnear

To 458422 ONTARIO LIMITED, 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 :

The licensee is ordered to:

1. Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment. The interventions identified in the Health Canada 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 surface such as low air loss mattresses (LAL). This will be done using an individualized, systematic and documented approach. These actions must be completed within 14 days of this order being served.

2. Where bed rails are used, evaluate any bed systems that were modified after the May, 2017, bed system evaluation, in accordance with evidence-based practices in order to minimize risk to the resident. Where it is unknown whether the bed system was or was not modified after the May, 2017, bed system evaluation, evaluate the bed system. This must be completed within 14 days of this order being served.

3. 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 Health Canada companion document titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (U.S. FDA, June, 2006).

4. Amend the process by which residents are assessed for the use of bed rails. Ensure all residents with one or more bed rails in use, and all residents for which the use of one or more bed rails is being considered, are individually assessed by an interdisciplinary team. The assessment process shall include a sleeping environment assessment; and shall include all factors, elements and conditions outlined in the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003). As well, the process shall consider the general guidance outlined within the Treatment Programs/Care Plans section of the FDA 2003 clinical guidance document.

5. Ensure that the interdisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes which may serve as alternatives to bed rail use; and, that the interventions or changes are trialed if appropriate and dependent on the resident assessment.

6. Ensure that the interdisciplinary team clearly documents all assessments and the results of the assessment or reassessment, including the risk-benefit analysis and ensuing recommendations.

7. Ensure that the interdisciplinary team reassess all residents for the use of bed rails, at a minimum, whenever there is a change in the resident's health status, as recommended in the Health Canada Guidance Document.

8. Update the written plan of care based on the resident assessment or reassessment by the interdisciplinary team for all residents where bed rails are used. Include all required information as specified in the FDA, 2003 clinical guidance document. Provide clear directions and include in the written plan of care any necessary accessories or interventions that are required to mitigate any identified bed safety hazards.

Grounds / Motifs :

1. The licensee has failed to ensure that where 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.

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

The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003) (the companion document). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. It is identified in the document that the population at risk for entrapment includes residents who are frail or elderly, and/or those who have conditions which cause them to move about in bed and/or try to exit from the bed. This includes conditions such as: agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction and acute urinary retention that cause them to move about the bed or try to exit from the bed. Other contributing risk factors are also identified in the companion document, including the absence of timely nursing care and technical issues related to the bed system.

According to the companion document, evaluation is needed to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. A decision regarding the use of bed rails is to be made within the context of an individualized resident assessment using an interdisciplinary team, and with input from the resident and family or SDM. This process is to include 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 consider numerous factors including (but not limited to) the resident's medical needs, sleep habits and patterns, cognition, mobility (in and out of bed), risk of falling, and the sleeping environment.

Diagnoses, symptoms, conditions and/or behavioral symptoms for which the use of a bed rail is being considered are to be addressed. Nursing/medical and environmental interventions are to be identified. If clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed need; or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used. Documentation of the risk-benefit assessment is required. The decision to use bed rails is to be approved by the interdisciplinary team that assessed the resident; and the effectiveness of the bed rail is to be reviewed regularly.

On August 29, 2017, Inspector #655 observed the bed system belonging to resident #033. Two ¼ length bed rails were observed to be in the up position at that time. At the time of the observation, both rails were observed to be slightly loose. In addition, there was a hand-width space between the headboard and the top of the mattress; and no mattress keepers were observed. On September 7 and again on September 12, 2017, Inspector #655 observed the same two ¼ length bed rails to be in the up position.

On August 29, 2017, Inspector #655 observed the bed system belonging to resident #034. From the foot of the bed, the left ¼ length bed rail was observed to be in the up position at that time. At the time of the observation, the left rail was observed to be loose; and there was a hand-width space between the inside surface of the left rail and the mattress. On September 7 and again on September 12, 2017, the same ¼ length bed rail was observed to be in the up position.

On August 29, 2017, Inspector #655 observed the bed system belonging to resident #036. At the time of the observation, two ¼ length rails were in the up position. From the foot of the bed, the right rail was in the assist position (vertical) and the left rail was in the guard position (horizontal). At the time of the observation, the right assist rail was observed to be loose; and there was a hand-width space between the headboard and the mattress and between the footboard and the mattress. On September 7 and again on September 12, 2017, both bed rails were observed to be in the same up positions.

On August 30, 2017, Inspector #655 observed the bed system belonging to resident #028. From the foot of the bed, the left ¾ length bed rail was observed to be in the up position at that time. At the time of the observation, a hand-width space was observed between the headboard and the mattress. The mattress was not squarely on the mattress deck – an area of the upper left portion of the mattress deck was exposed, creating a hand-width space between the inside surface of the left rail and the outside edge of the mattress. There were no mattress keepers observed on the bed system. The same rail was observed to be in the up position on September 7 and again on September 12, 2017.

On August 30, 2017, Inspector #655 observed the bed system belonging to resident #038. Two ¼ length bed rails were observed to be in the up position at that time. From the foot of the bed, the right rail was observed to be in the guard position (horizontal) and the left rail was observed to be in the assist position (vertical). At the time of the observation, the left assist rail was looser when compared to the right rail. There was a hand-width space between the headboard and the mattress; and between the footboard and the mattress. On September 7 and again on September 12, 2017, the same two bed rails were observed to be in the up position.

During an interview on September 8, 2017, PSW #108 indicated to inspector that all five of the above-noted residents (#'s 028, 033, 034, 036, and 038) use one or more bed rails regularly. PSW #108 was unable to speak to a process in place for assessing residents prior to the implementation of bed rails; however, PSW #108 indicated to Inspector #655 that any assessment that is done would be done by a member of the registered nursing staff.

During an interview on September 8, 2017, RN #113 referred to a "Bed Rail Assessment" form that is used to assess residents for the use of bed rails. RN #113 indicated to Inspector #655 that the purpose of the "Bed Rail Assessment" is to determine whether a given resident is safe to have a bed rail or whether it would be safer for that resident not to have a bed rail. During the same interview, RN #113 indicated to Inspector #655 that the nurse does not normally complete the "Bed Rail Assessment"; rather, it is completed by the RAI Coordinator.

Inspector #655 reviewed the health care records belonging to the five above-noted residents (#'s 028, 033, 034, 036, and 038). On review of the residents' hard copy and electronic health care records, Inspector #655 was able to locate

resident #036. The "Bed Rail Assessment" was completed over two years ago, for resident #024; and over one year ago, for resident #036.

On review of the "Bed Rail Assessment" forms completed for resident #034 and resident #036, it was found that the "Bed Rail Assessment" was not in accordance with the current prevailing practices identified in "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (U.S. FDA, 2003), one of the companion documents to the HC Guidance Document. The "Bed Rail Assessment" did not address, for example, the resident's sleep habits, sleeping environment or level of comfort in bed (i.e. pain, hypoxia). Factors such as toileting needs and medications were also not addressed in the "Bed Rail Assessment". In addition, no clear documentation of a risk-benefit analysis was observed.

Inspector #655 was unable to locate any documentation to indicate that resident #'s 028, 033, or 038 had been assessed for the use of bed rails prior to their implementation; nor any documentation to indicate that a risk-benefit analysis had been completed for any of these three residents with regards to the use of bed rails.

During an interview on September 12, 2017, the RN #100 was also unable to locate a "Bed Rail Assessment form" for resident #028, #033, or #038. According to the Registered Nurse, resident #028 was not assessed using the "Bed Rail Assessment" form because the bed rails in place for resident #028 were considered to be a restraint; and for that reason, resident #028 had been assessed using the "Restraint/PASD Assessment" form. During the interview, it was discussed that certain elements identified in the companion document (FDA, 2003) such as a residents toileting needs and comfort in bed were not addressed in either the "Bed Rail Assessment" or the "Restraint/PASD Assessment" forms. The Registered Nurse was unable to speak to a process through which these considerations were made in the process of assessing resident's for the use of bed rails.

During interviews on September 6 and September 12, 2017, RAI Coordinator #119 indicated to Inspector #655 that the "Bed Rail Assessment" form was the only tool being used to assess residents for the use of bed rails. RAI Coordinator #119 was not aware of any processes in place through which the various elements outlined in the companion document (FDA, 2003) would be considered

when assessing residents for bed rail use in the home. RAI Coordinator #119 further indicated to Inspector #655 that residents are assessed using the "Bed Rail Assessment" form on admission. At the same time, RAI Coordinator #119 indicated to Inspector #655 that quarterly assessments related to a residents' use of bed rails were primarily a "review", not documented, and done primarily when a bed rail is considered to be a restraint. RAI Coordinator #119 indicated to Inspector #655 that shorter bed rails are often implemented based on the request of the resident and/or family.

During the same interview, RAI Coordinator #119 confirmed that there had been no "Bed Rail Assessment" form completed for either resident #038 or resident #033. RAI Coordinator #119 indicated to Inspector #655 that the "Bed Rail Assessment" forms had been implemented approximately two years ago; and that residents' who were admitted prior to that time may not have been assessed for the use of bed rails prior to the bed rails being implemented.

Over the course of the inspection, it was also noted by Inspector #655 that resident #029 and #039 also used one or more bed rails. Inspector #655 was unable to locate a "Bed Rail Assessment" for either resident.

During an interview on September 15, 2017, the home's Administrator indicated to Inspector #655 the "Bed Rail Assessment" form is the only assessment tool being used to conduct a clinical assessment of resident with regards to bed rail use. The Administrator indicated to Inspector #655 that the purpose of the "Bed Rail Assessment" is to assess each resident for both the need and their safety in using bed rails.

The licensee has failed to ensure that where bed rails are used, residents, including resident #028, 029, 033, 034, 036, 038, and 039, are assessed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

In addition to providing guidance regarding the clinical assessment of residents, 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 (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-

4).

It is recognized in the HC Guidance Document that legacy beds have the potential for dimensional change over time through wear and tear or substitution of bed components. According to the HC Guidance Document, a bed system may require re-evaluation when there is reason to believe that a bed system component is worn (for example, the rails wobble or are loose). As indicated in the HC Guidance Document, a lateral shift and/or degree of play from a loosened bed rail is a factor which may increase the gap size in potential entrapment Zones 2 (under the rail, between supports), 3 (between the rail and the mattress), and 4 (under the rail at the ends of the rail).

On August 29 and August 30, 2017, Inspector #655 observed the bed systems belonging to resident #'s 028, 033, 034, 036, and 038. Each of the bed systems were observed to have one or more bed rails in the up position; and were observed to have one or more loose bed rails, and/or gaps between the mattress and a bed rail and/or foot or headboard, as previously described.

In May 2017, all bed systems in the home were evaluated in accordance with the methods outlined in the HC guidance document. The bed system evaluations were done by an outside service provider. Inspector #655 reviewed the results of the bed system evaluations on a document provided to Inspector #655 by the Administrator on September 7, 2017.

On the bed system evaluation results document, there was a note that read: "if zones 1-4 pass entrapment testing a passing grade will be issued". Another note that read: "If any zones between 1-4 fails entrapment testing a failing grade will be issued"; and, "if zones 5,6 or 7 fails then a passing grade is issued but these zones should be addressed to ensure resident safety".

According to the bed system evaluation results document, provided to Inspector #655 by the Administrator 36 out of 52 (over 69%) of the bed systems in the home were given a failing grade, as one or more of the potential zones of entrapment with prescribed dimensional limits (zones 1-4) exceeded the prescribed dimensional limits.

Of the five bed systems that were observed by Inspector #655 on August 29 and August 30, 2017, all five were given a failing grade. Those were the bed systems belonging to resident #'s 028, 033, 034, 036, and 038. According to the bed

system evaluation results document:
- The bed system belonging to resident #028 exceeded the prescribed dimensional limits in the areas of zone 2 and zone 4;
- The bed system belonging to resident #033 exceeded the prescribed dimensional limits in the areas of zone 2 and zone 4;
- The bed system belonging to resident #034 exceeded the prescribed dimensional limits in the area of zone 4;
- The bed system belonging to resident #036 exceeded the prescribed dimensional limits in the area of zone 2; and,
- The bed system belonging to resident #038 exceeded the prescribed dimensional limits in the area of zone 2.

On the bed system evaluation results document, dated May, 2017, recommended solutions to address bed system failures, including the above-noted failures, are identified.

For bed systems that exceeded the prescribed dimensional limits in the area of zone 2 only (bed systems belonging to resident #036 and resident #038), the recommended solution was to tighten the rails. For bed systems that exceeded the prescribed dimensional limits in the area of zone 4 - including those that failed in both the areas of zone 2 and 4 - (bed systems belonging to resident #'s 028, 033, 034), the recommended solution was to replace the mattress with a specified type of mattress.

On September 8, 2017, Inspector #655 observed the bed systems belonging to resident #'s 028, 033, and 034 (those identified on the bed system evaluation document as requiring a new mattress), while accompanied by Maintenance Staff #120. During this time, it was observed that the mattresses on these bed systems were dated April 1, 2011; June 20, 2014; and, September 9, 2015, respectively. During an interview at the same time, Maintenance Staff #120 reviewed the process in place at the home for the monitoring of mattresses. According to Maintenance Staff #120, the tag on each of the mattresses would have been dated at the time it that it was placed onto the bed system. That is, if the hand-written date on the mattress tag was April, 2011, (as it was for the bed system belonging to resident #028), this would been the date on which that mattress was placed on that resident's bed system. Based on observations and discussion with Maintenance Staff #120, there was no indication that the recommended solution, a mattress change, had been implemented in order to minimize the risk of entrapment for any of the three above-noted bed systems.

According to Maintenance Staff #120, however, RPN #115 would have tracked any mattress changes that did occur. Maintenance Staff #120 was not aware of any other interventions or modifications made to the failed bed systems which required a mattress change as a result of the bed system evaluation process in May, 2017.

During an interview on the same day, Maintenance Staff #120 further indicated to Inspector #655 that for any bed systems that were identified as a result of the bed system evaluation process as requiring the bed rails to be tightened, those bed rails had been tightened, including the bed systems belonging to resident #'s 036 and 038. At the same time, Maintenance Staff #120 indicated to Inspector #655 that he was not sure whether the bed systems were evaluated after the bed rails had been tightened in order to ensure that the action of tightening the bed rails had corrected the zone failures.

During an interview on September 12, 2017, RPN #115 indicated to Inspector #655 that where a bed system was identified as a result of the bed system evaluation process as requiring a new mattress, the mattress had not yet been changed. RPN #115 explained to Inspector #655 that based on the results of the May, 2017, bed system evaluations, approximately 25 new mattresses were required to be purchased (24 based on review of the bed system evaluation results document). RPN #115 indicated to Inspector #655 that she was not aware of any interventions that were implemented in the interim in order to address the risk associated with bed system failures.

During an interview on the same day, RPN #115 also indicated to Inspector #655 that where bed rails were tightened as a result of the bed system evaluation process, those bed systems were not evaluated after the bed rail(s) had been tightened. It was noted by Inspector #655 that, according to the bed system evaluation results document, 12 bed systems were identified to require that the bed rails be tightened. RPN #115 provided Inspector #655 with a hand-written list (titled "Bed Entrapment Audit") of bed systems identified as having loose bed rails contributing to zone failures as a result of the bed system evaluation process. According to RPN #115, if there is a check-mark next to the bed system, it is indicative that the bed system rails had been tightened as recommended. According to the "Bed Entrapment Audit" list, the bed rails had been tightened on all 12 of the identified bed systems. RPN #115 indicated to Inspector #655 that the cone and cylinder tool used for bed system evaluations was not accessible in the home.

Where bed rails were tightened in order to address bed system failures, there was no process in place to evaluate whether the action resulted in a bed system that would meet the requirements of the prescribed dimensional limits. The bed systems were not evaluated in accordance with prevailing practices after the bed rails were tightened, in order to minimize risk to the resident.

During an interview on September 12, 2017, the Administrator indicated to Inspector #655 that she was not aware of any mattress changes having taken place following the May, 2017, bed system evaluations to date. The Administrator indicated to Inspector #655 that the recommended type of mattress was not available in the home at this time. The Administrator indicated to Inspector #655 that the recommended type of mattress had not yet been ordered. At the same time, Administrator #124 was unable to speak to any interventions that had been implemented in the interim in order to minimize the risk associated with the identified bed system failures.

Upon becoming aware that a total of 36 resident bed systems were evaluated to have one or more failed potential zones of entrapment in May, 2017, the licensee did not take steps to prevent resident entrapment, taking into consideration the failed potential zones of entrapment.

As the non- compliance described above is widespread, and presents the risk of entrapment, a compliance order will be served on the licensee. [s. 15. (1) (a)] (655)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 24th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

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