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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 6, 2018	2018_617148_0002	016094-17, 016278-17, 016281-17	Follow up

Licensee/Titulaire de permis

TAMINAGI INC.
5 Loiselle Street CP Box 2132 Embrun ON K0A 1W1

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

SARSFIELD COLONIAL HOME
2861 Colonial Road P.O. Box 130 Sarsfield ON K0A 3E0

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 24, 25, 26, 29, 30 and 31, 2018

This inspection was to follow up with three Compliance Orders (CO) that were issued as a result of the Resident Quality Inspection (RQI) #2017_619550_0015. The COs related to 24 hour registered nurse on duty (CO #001), bed rails (CO #002) and the nutritional care program (CO #004).

In addition, CO #003 from the same 2017 RQI was complied with in September 2017, as it relates to Inspection Report #2017_625133_0014. The compliance of this Order has been noted in this inspection report.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Assistant Director of Care, Human Resources, RAI Coordinator, Registered Dietitian/Nutritional Manager (RD/NM), the General Manager, Activty Director, Registered nurses (RN), Registered Practical Nurses (RPN), Food Service Workers (FSW), Personal Support Workers (PSW), Cooks an d residents

In addition, the Inspector observed the resident care environment including bed systems and related equipment along with several meal services. The inspector reviewed the health care records of identified residents, documents used by the dietary department including menus and planned therapeutics, documents related to the bed evaluation and resident assessments conducted related to the use of bed rails along with nursing staffing schedules and policies related to the staffing back up plan.

The following Inspection Protocols were used during this inspection:
Dining Observation
Safe and Secure Home
Sufficient Staffing

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

- **3 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #003	2017_619550_0015	148
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2017_619550_0015	148

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 :

The licensee has failed to ensure that where bed rails were used, residents were assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident and steps are taken to prevent resident entrapment, taking into consideration all potential zone of entrapment.

On June 23, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Resident Quality Inspection (RQI) #2017_619550_0015. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by September 21, 2017.

The licensee was ordered, in part, to take the following action:
1. Establish and implement a process that for when bed rails are used, the resident is to be assessed for the need of these bed rails in accordance with prevailing practices;
2. Establish and implement a process for when bed rails are used, that the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize the risk of resident entrapment, taking into consideration all potential zones of entrapment;
3. The resident is followed by an interdisciplinary team for assessment of the ongoing need and use for these bed rails, including quarter or half rails. This interdisciplinary team is to be consulted before the decision to add/change the style of bed system, bed rails or mattress used for residents; and
4. Ensure that the above assessments and reassessments are documented including the

names of team members participating in the assessment, the results of the assessment, and the recommendations for these residents in relation to their bed system and rails.

In August, 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (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).

The HC guidance document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) of 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). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is specified that any decision to use or to discontinue use of bed rails should be made within the context of an individualized resident assessment using an interdisciplinary team. Numerous factors are to be considered in the resident assessment including: medical diagnosis, conditions, symptoms and/or behavioural symptoms; sleep habits; medication; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling, etc. The process is to result in a documented risk benefit assessment, prior to the team's conclusion that bed rails may be indicated for use. Specific direction is provided in relation to three aspects of the required risk benefit assessment, and they are as follows:

a) Assessment of the relative risk of using bed rails compared with not using bed rails for each individual resident.

b) Identification of why other care interventions are not appropriate or not effective if previously attempted and determined not to be the treatment of choice for the resident.
c) 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 2003 FDA Clinical Guidance document specifies that where clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be indicated for use. The decision to use or to discontinue use of bed rails is to be made by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Sarsfield Colonial Home is located in a rural community and has 46 licenced beds. It was identified during the time of the inspection that the home had various bed rails in use, most commonly used were rotating assist rails along with ¾ and full length rails.

On January 25, 2018, the home's Administrator identified the Director of Care and RAI Coordinator as the two leads responsible for ensuring compliance with O.Reg 79/10, s.15 (1) and the Compliance Order of June 23, 2017. The Administrator expressed that all work had been completed regarding the requirements of the Compliance Order.

On January 25, 2018, Inspector #148 spoke with the RAI Coordinator who indicated that she had participated in the resident assessment related to the use of bed rails. She described that for each resident using bed rails that an assessment was done to ascertain if the resident was cognitively able to use the bed rails as a mobility device. She indicated that if the resident was cognitively able, that the rails remained in use. If the resident was not cognitively able to use the rails, the rails would be removed. She noted that where a resident required, other interventions were put in place as they related to the risk of falls (exampled by lowering the bed frame and use of fall mat). To further clarify, the RAI Coordinator said that bed rails were previously used for mobility and/or fall risk, since having completed the assessment of each resident, bed rails are now only in use for mobility; also noting that some bed rails are in use at the preference of the resident and/or substitute decision maker.

The RAI Coordinator identified the Assessment of Assisting Rail document (assessment document) that was used to conduct the resident assessment. The assessment document provides for the following statement:
"Resident (name) has been assessed by the Director of Care, or delegate and RAI-C for

criteria of utilization of assisting rail as per Ministry of Health Standards."
Proceeding this statement is the following:
"Resident cited above; meets the requirements for safe use of side rails; Do not meet the requirements of the safe use of side rails."

The RAI Coordinator indicated that either the resident would be identified as meeting the requirements or not meeting the requirements. If the resident met the requirements the bed rail(s) would stay, if the resident did not meet the requirements the bed rail(s) would be removed. She had understood that the requirements included weather or not the resident was cognitively able to use the bed rail. When asked by the Inspector, the RAI Coordinator was not familiar with the HC guidance document or companion documents.

On January 25, 2018, Inspector #148 spoke with the home's DOC regarding the compliance of O.Reg 79/10, s.15. The DOC reported that in consultation with the Professional Advisory Committee, she development the Assessment for Assisting Rail document. The DOC reported that she had completed this assessment documented with all residents with one or more bed rails in use, in December 2017. During a review of the assessment document with the DOC, the DOC reported that she was not familiar with the HC guidance document, however, had a copy of A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment (a companion document to the HC guidance document). She indicated that this guide was not used in the development of the assessment document.

In discussion with the DOC about the content of the assessment document, the Inspector questioned the meaning of "meet the requirements for safe use" and "Ministry of Health standards". The DOC identified the standard/requirement to be that if the resident is unable to use the rail in transfer or positioning then the rail has to be removed as there is a high risk of entrapment. When asked, the DOC could not find where she had identified this statement as a Ministry of Health standard or requirement. In this way, no other factors were considered when the assessment of the resident was conducted.

It was determined that the licensee had not established and implemented a process for the individualized resident assessment in accordance with prevailing practices (2003 FDA Clinical Guidance document). The interdisciplinary team, including the DOC and RAI Coordinator, conducted an assessment of the resident's use of bed rails; no resident assessment was conducted with consideration of factors including: medical diagnosis, conditions, symptoms and/or behavioural symptoms; sleep habits; medication; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of

bed); risk of falling, etc.

The Inspector reviewed the documents provided by the home's DOC related to the resident assessment; in review of these documents and identified resident health care records, the Inspector could not locate a documented risk benefit assessment. The Inspector discussed the concept of a risk benefit assessment with both the RAI Coordinator and DOC, who both indicated that risk benefit assessments were not completed for residents.

During the interview, on January 25, 2018, with the DOC, a document titled Resident Safety devices/Assisting rail/Restraint Checklist was provided to the Inspector. The DOC reported that this document summarized each resident's need for bed rails based on the assessment completed using the Assessment of Assisting Rail document, of which were completed during a one week span in late December 2017. In addition to this document, the DOC provided a document titled Assisting Rail Ready To Be Removed; a document that listed those residents who required one or more bed rails to be removed. It was noted by the Inspector that this document identified at least five residents on a specified unit who were to have two bed rails removed, each of whom had not yet had those rails removed. The DOC indicated that the maintenance personnel was working through the home to ensure that identified bed rails were removed, however, not all had been done.

The Inspector identified the five residents as resident #003, #006, #007, #008 and #009. Each of the five residents were observed on January 24 and/or 26, 2018, to have at least one bed rail in use while the resident was in bed during a rest period. Residents #008, #006 and #004 were observed with two rails in use and residents #009 and #003 with one rail in use. All of the five residents were listed on the Resident Safety Devices document as having no bed rails.

The health care record was reviewed for each of the five residents and the following was noted:
Resident #003 – plan of care indicates the use of bed rail(s), resident attempts to self transfer, fall risk; identified medical diagnosis; Assessment for Assisting Rail document, dated December 2017, indicated that the resident did not meet requirements for the use of bed rails.
Resident #004 – plan of care indicates the resident use of bed rail(s); identified medical diagnosis; Assessment for Assisting Rail document, dated December 2017, indicated that the resident did not meet requirements for the use of bed rails.

Resident #006 – plan of care indicates the resident is dependent on staff for care including bed mobility, bed rails in use, responsive behaviours noted; identified medical diagnosis; Assessment for Assisting Rail document, dated December 2017, indicates that the resident did not meet the requirements for use of bed rails.
Resident #008 – plan of care indicates the resident is dependent on staff for care including bed mobility, bed rails in use, responsive behaviours noted and risk of falls; identified medical diagnosis; Assessment of Assisting Rail document, dated December 2017, indicates that the resident did not meet the requirements for use of bed rails.
Resident #009 – plan of care indicates the resident is dependent on staff for care including bed mobility, has a fall risk and responsive behaviours; identified medical diagnosis; Assessment of Assisting Rail document, dated December 2017, indicates that the resident did not meet the requirements for use of bed rails.

The licensee completed an assessment of bed rail use, using the Assessment of Assisting Rail document and determined that the above five residents did not use the bed rails and that the rails should be removed. The Inspector reviewed the resident health care records and identified factors that would impact on the entrapment risk of the resident. The Inspector observed these identified rails to remain in use approximately one month after the need for removal was identified by the DOC and RAI Coordinator.

During the interview with the DOC, on January 25, 2018, it was identified that the General Manger was the lead for completion of the bed system evaluations. The Inspector spoke with the General Manager on January 29, 2018. The GM reported that he and a maintenance staff member #122, had conducted the bed evaluations for each resident. He indicated that an external company had provided training to both himself and staff member #122 and had lent them the cone and cylinder tool to conduct the bed system evaluations. Further to this, the GM noted that he had referenced two Health Canada documents, including the HC guidance document and one of the companion documents titled A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment.

Upon further discussion, the GM reported that all bed system evaluations had been completed at the end of October 2017. He was not able to provide any documented bed evaluations to support the completion, but reported that he recalled three bed systems failing at least one zone and that as a result the bed rails on those three bed systems were removed. When asked, the GM was not able to identify the bed system, room or resident involved in these failures or the zones that had failed. Given the observed use of

rotating assist rails in the home, the Inspector asked about evaluations/testing completed for intermediate positions, for applicable zones. The GM was not able to confirm that such evaluation/testing had been completed.

It was further shared that a record of a complete inventory of bed systems in the home was not maintained at this time. This was exampled, in that during the competition of bed evaluations, information regarding the bed frame was recorded but not the mattress.

The Inspector conferred with the home's Administrator on January 31, 2018, as to the whereabouts of any documented bed system evaluations. At that time the home could not provide documents to support the completion of bed evaluations.

During the interview with the GM, the Inspector questioned if any of the bed systems in the home had been modified since the bed system evaluations in October 2017. The GM did to believe any modifications has been made as they would be communicated to him; he was aware of maintenance staff removing rails based on the resident assessments completed by the home's DOC.

In review of the Assisting Rail Ready to be Removed document, previously noted in this report, and through discussion with the DOC, it was indicated that where a resident was listed as "remove 1 (left or right)", that these residents had two bed rails in use and that one of the bed rails was to be removed. The same document, identified 18 residents who required a change in current use of bed rails. For most residents it was to have two bed rails reduced to one; three residents were identified as needing a ¾ rail reduced to an assist rail. As indicated by the DOC, decisions to change the number or type of bed rail for a resident was determined in December 2017 when the Assessment of Assisting Rail document was completed (as previously discussed in this report). Of the 18 residents, 13 residents had their existing two bed rails reduced to one bed rail, as maintenance staff had removed the second bed rail in use. The Inspector was able to observe five of these identified residents with one bed rail in use. As confirmed by the GM, bed evaluations were completed in October 2017 and no further evaluations had been completed. The documents reviewed indicate that there were changes to the side rails, however there was no evaluation to ensure that the bed system continued to meet the recommendations of the HC guidance document.

The licensee did not ensure that the bed system evaluations were completed, in accordance with the HC guidance document, specifically related to record keeping of the bed system evaluations and bed system inventory, the implementation of bed system

evaluations (including testing of intermediate positions) and ensuring that bed systems are re-evaluated when there are changes to the bed system.

In accordance with the HC guidance document, the term "entrapment" describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail"

During an interview with the Director of Care, it was indicated that in December 2017, resident #002 had been identified as a resident that does not use the two rotating assist bed rails that were applied to the bed. This was identified by the Assessment for Assisting Rail document, however the rails remained in use at the request of the resident's substitute decision maker. In further discussion about this resident, the DOC reported that the resident moves a lot in bed and was found caught at the top of the bed with his/her upper body out of the bed. The Inspector later reviewed the home's incident report of a specified date and spoke with RN #118 and PSW #121 who were present at the time of the incident. PSW #121, who had discovered the resident indicated that during rounds, she entered the bedroom of resident #002 and observed the resident half off the bed, including the resident's upper body, head, neck and breast over the bed. Upon further description the PSW noted that the resident's night clothes were tight around the resident's neck; no signs of distress were noted. The PSW proceeded to reposition the resident back into bed, providing extra pillows for positioning and reported the incident to RN #118. PSW #121 confirmed that the resident had two bed rails in use at the time and that the resident's lower torso and legs were held in the bed by the bed rail, while the upper body was hanging off the side of the bed.

Resident #002 was admitted on a specified date with diagnosis that would affect mobility. The current plan of care notes the resident's dependence on staff for activities of daily living, behaviours and decline in cognition. Upon review of the resident's health care record, a progress note dated one day after the entrapment incident, indicated that padding would be applied to the bed rails. A subsequent progress note three days after the incident, indicates that a discussion had taken place with the resident's substituted decision maker and that the bed rails were to be removed.

Inspector #148 observed resident #002 in bed on January 24, 25 and 26, 2018, with two rotating assist rails in the horizontal position (one rail on each side of the bed, located at mid length of the bed) with padded cover on both bed rails. At the time of observation the bed rails had not yet been removed and were still in use for resident #002.

The licensee did not ensure that a resident assessment for resident #002 was conducted, in accordance with prevailing practices; nor can the home demonstrate that the bed system was evaluated in accordance with best practice, as referenced above earlier in this report. After the incident, as described above, steps were not taken to prevent resident entrapment, taking into consideration all potential zone of entrapment.

Over the course of this inspection it was noted that several residents have various bed rails in use, predominately rotating assist rails, indicating that this non-compliance affect many residents in the home and is widespread. It was determined that residents who were identified in December 2017 to not use rails continue to have such rails in use and that evidence collected during this inspection indicates that both the resident assessment and bed system evaluations were not conducted in accordance with the HC guidance document. Additionally, an entrapment incident was identified to have occurred, subsequent to the entrapment incident identified in the grounds of CO #002 (RQI report of 2017). Such indicates that this non-compliance presents actual harm with previously identified non-compliance. The scope, severity and compliance history support the issuance of this Compliance Order.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle includes: menus for regular, therapeutic and texture modified diets for both meals and snacks and alternative choices of entrees, vegetables and desserts at lunch and dinner.

On June 23, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 71 as a result of Resident Quality Inspection (RQI) #2017_619550_0015. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by August 18, 2017.

The licensee was ordered, in part, to take the following action:
The licensee shall ensure that menu planning includes:
1. Menus for texture modified diets for both meals and snacks
2. The meal menu shall include alternative pureed choices of entrees, vegetables and desserts at lunch and dinner
3. The snack menu shall include a pureed snack option in the afternoon and evening
4. Offering each resident a minimum of three meals daily.

On January 24, 2018, the Inspector spoke with the home's RD/NM, who had been recently hired in the fall of 2017. The RD/NM was aware of the outstanding Compliance

Order and applicable legislative requirements. She indicated that upon her arrival to the home she noted several concerns with the dietary program that required attention. She reported that among other items, she developed a four week menu with specific changes to improve nutritional quality. In addition, she had purchased new equipment including dining room tables, made changes to the meal times, implemented course by course service and reviewed the program as it related to food safety and staff training.

Upon the Inspector's review, it was confirmed that the RD/NM had developed a four week menu for three meals and between meal snack and beverages for the regular diet, regular texture. At the present time she had completed most work for the Week 1 therapeutic menu, which includes a menu for puree and minced texture modifications at meals. The therapeutic menu was not yet implemented for staff use. In addition, the RD/NM had developed production sheets for Week 1 and 2 of the menu. At this time there were no therapeutic menus for Week 2, 3 and 4 for the meals and no therapeutic menus developed for Week 1, 2, 3 and 4 for the snack menu. It was reported by the RD/NM that with the lack of therapeutics in place at this time, it was expected that staff follow the regular menu in the production of other therapeutic diets, such as the minced and puree texture modifications.

The Inspector observed the lunch meal service on January 24, 2018 and January 25, 2018 along with the breakfast meal service on January 25 and 26, 2018. The following were noted by the Inspector:
-On the first meal observation of January 24, 2018, there was one choice of puree vegetable. When the regular full time Cook #104, who was responsible to serve the lunch meal, was asked about the puree vegetable choice, he noted he is only required to make one puree vegetable at meals.
-During observations of the meals and snacks, the Inspector noted items such as pancakes, muffins, fruit and cookies as planned by the regular menu, were not prepared for the puree texture modification.
-On several occasions including the lunch on January 24, breakfast on January 26 and snack service on January 25, the dietary staff used leftover food items from previous meals to provide the dessert choice, fruit and snack, respectively. FSW #105 and FSW #110, who prepare such items for the puree modification, noted that leftovers are used to prepare the puree items when available from a previous meal. Both identified that they did not have a therapeutic menu to follow in the production of puree textured items.
-During the afternoon snack, PSW staff serving the snack, including PSW #106, indicated that the cookies available on the cart were appropriate for the minced texture, whereas PSW #107 indicated that she would serve the banana to those residents on

minced texture. PSW staff serving the snack were not clear on the food items appropriate for residents on texture modified diets. Both identified that they did not have a therapeutic menu to follow in the service of the minced items.
-During the lunch meal service of January 24 and 25, 2018, the Inspector noted that the puree textured food items were smooth, however, did not hold shape and had wide spread on the plate. In addition, it was noted that the portion size appeared reduced. It was observed that at each meal, the #16 scoop was consistently used for all puree and minced textured items along with the mashed potatoes.

As noted earlier in the report the staff producing and serving food did not have therapeutic menus to guide the production or provision of food items outside of the regular diet, regular texture. In review of the production sheets and available recipes, there were no directions to staff on the implementation of the puree and minced texture modified therapeutics; the staff did not have guidance in place related to scoop size (portion size) to use for meal service. As noted earlier, the staff serving the meal primarily used the #16 scoop; in review of standardized portions and the Week 1 therapeutic developed by the RD/NM, the planned scoop size for puree and minced items will be #12 and #10, with #8 for items such as mashed potato. Upon further review of the production program, it was noted that at this time there were no available recipes for the production of puree or minced texture modified items. Staff were not provided with guidance on the production of puree texture food items to ensure consistency of such products are reached (exampled by no lumps/holds shape).

In review of the Cardex, a document listing each resident in the home along with their diet, texture and nutritional interventions, it was noted by the Inspector that three residents were listed to require 1.5 portion size, four residents were identified to require small portion size and two residents were identified to require weight reducing diets. During interviews with Cook #104 and Cook #109, both of whom serve lunch meal service, the staff members had various interpretations of these nutritional interventions. The Cook staff members were not clear if all food items were reduced with the small portion size or what this portion size would be. Cook #104 could not identify any difference in the meal service for a resident listed to require 1.5 portions and the regular diet, nor could he identify any difference in the meal service for a resident listed to require weight reducing and the regular diet. At this time staff are not clear on the implementation of such nutritional interventions/therapeutic diets. The same was discussed with the RD/NM on January 30, 2018, to which the RD/NM confirmed there to be no planned therapeutic or other reference for staff to follow for these noted interventions.

At this time the home does not have a menu cycle that includes a planned menu for all therapeutics and texture modifications in the home, including such therapeutics for portion variations and weight reducing. The lack of development of menus, production sheets and recipes affect a wide scope of residents in the home with a potential risk of harm. In addition, the home has had a previous Compliance Order, as indicated in these grounds. The scope, severity and compliance history support the issuance of this Compliance Order related to O.Reg 79/10, s.71(1)(b) and (c). [s. 71. (1) (b)]

2. The licensee has failed to ensure that the evening meal is not served before 5:00pm (1700 hours).

The licensee has implemented two services for each meal (breakfast, lunch and supper) as follows:
Breakfast 0700 and 0800 hours
Lunch 1100 and 1200 hours
Supper 1645 and 1745 hours

As noted earlier in the report, the RD/NM had made changes to the meal service times for the breakfast and lunch service. The time of the supper meal service (1645) has been in place for some time which could not be specifically identified by the RD/NM or other dietary staff. At the present time the home serves the supper meal prior to 1700 hours (5:00pm), which is not supported by the legislative requirements. [s. 71. (6)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, a review of the meal and snack times by the Residents' Council.

The licensee has implemented two services for each meal (breakfast, lunch and supper) as follows:
1st Service - Breakfast 0700, Lunch 1100
2nd Service – Breakfast 0800, Lunch 1200

As noted earlier in the report, the RD/NM had made changes to the meal service times for the breakfast and lunch service to provide a better balance between meal times. Prior to the RD/NM arrival she reported the meal service times to be as follows:
1st Service - Breakfast 0730, Lunch 1200
2nd Service – Breakfast 0800, Lunch 1100

Upon discussion with the RD/NM and the home's Activity Director (liaison to the Resident Council) it was determined that the change in meal times had not been discussed with the Council. [s. 73. (1) 2.]

Issued on this 7th day of February, 2018

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)
Inspection No. / No de l'inspection :	2018_617148_0002
Log No. / No de registre :	016094-17, 016278-17, 016281-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 6, 2018
Licensee / Titulaire de permis :	TAMINAGI INC. 5 Loiselle Street, CP Box 2132, Embrun, ON, K0A-1W1
LTC Home / Foyer de SLD :	SARSFIELD COLONIAL HOME 2861 Colonial Road, P.O. Box 130, Sarsfield, ON, K0A-3E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHANTAL CRISPIN

To TAMINAGI INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_619550_0015, CO #002;

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 :

1. Re-evaluate all bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document). In consideration of rotating assist rails, all intermediate positions are to be evaluated. The zone specific test results are to be documented.

2. Establish and implement a process for ensuring that any bed system failures are addressed immediately. Document corrective actions taken. Consider the guidance outlined in the FDA 2006 document "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment", a companion document to the HC guidance document. Should it be unavoidable that a resident must remain in a bed system that fails the prescribed entrapment zone testing, for any period of time, take immediate steps to prevent resident entrapment, taking into consideration all potential zones of entrapment. Steps taken are to be documented.

3. Maintain a bed system inventory that includes all relevant identifying information for each bed system in use for each resident and which reflects the

most recent evaluation for each bed system. Ensure that a re-evaluation of a bed systems is completed as required, such as when a new bed system is created as a result of a change or replacement of components, and when there is reason to believe some components are worn (eg. Rails wobble or are damaged, mattresses are softer).

4. Establish and implement a process for ensuring that all residents with bed rails are assessed in accordance with the 2003 FDA clinical guidance document. As per the 2003 FDA clinical guidance document, if clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower that of other interventions or of not using them, bed rails may be indicated for use. The use of bed rails is to be approved by the interdisciplinary team.

5. The resident assessment along with the names of the team members who participate in the assessment and decision making process, including the risk benefit assessments, is to be documented.

6. Ensure that the interdisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes, which may serve as alternative to bed rail use, and that the interventions or changes are trialed if appropriate and dependent on the resident's assessment, during a specified observation period prior to the application of any bed rails or prior to the removal from use of any bed rails. The trail of alternatives to the use of bed rails is to be documented.

7. Develop and implement a documented ongoing auditing process to ensure that all requirements of this compliance order are satisfied.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, residents were assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident and steps are taken to prevent resident entrapment, taking into consideration all potential zone of entrapment.

On June 23, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Resident Quality Inspection (RQI) #2017_619550_0015. The order type was as per LTCHA, 2007, s. 153 (1) (a), in

that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by September 21, 2017.

The licensee was ordered, in part, to take the following action:
1. Establish and implement a process that for when bed rails are used, the resident is to be assessed for the need of these bed rails in accordance with prevailing practices;
2. Establish and implement a process for when bed rails are used, that the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize the risk of resident entrapment, taking into consideration all potential zones of entrapment;
3. The resident is followed by an interdisciplinary team for assessment of the ongoing need and use for these bed rails, including quarter or half rails. This interdisciplinary team is to be consulted before the decision to add/change the style of bed system, bed rails or mattress used for residents; and
4. Ensure that the above assessments and reassessments are documented including the names of team members participating in the assessment, the results of the assessment, and the recommendations for these residents in relation to their bed system and rails.

In August, 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (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).

The HC guidance document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) of 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). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is specified that any decision to use or to discontinue use of bed rails should be made within the context of an individualized resident assessment using an interdisciplinary team. Numerous factors are to be considered in the resident assessment including: medical diagnosis, conditions, symptoms and/or behavioural symptoms; sleep habits; medication; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling, etc. The process is to result in a documented risk benefit assessment, prior to the team's conclusion that bed rails may be indicated for use. Specific direction is provided in relation to three aspects of the required risk benefit assessment, and they are as follows:

a) Assessment of the relative risk of using bed rails compared with not using bed rails for each individual resident.
b) Identification of why other care interventions are not appropriate or not effective if previously attempted and determined not to be the treatment of choice for the resident.
c) 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 2003 FDA Clinical Guidance document specifies that where clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be indicated for use. The decision to use or to discontinue use of bed rails is to be made by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Sarsfield Colonial Home is located in a rural community and has 46 licenced beds. It was identified during the time of the inspection that the home had various bed rails in use, most commonly used were rotating assist rails along with ¾ and full length rails.

On January 25, 2018, the home's Administrator identified the Director of Care and RAI Coordinator as the two leads responsible for ensuring compliance with O.Reg 79/10, s.15 (1) and the Compliance Order of June 23, 2017. The Administrator expressed that all work had been completed regarding the requirements of the Compliance Order.

On January 25, 2018, Inspector #148 spoke with the RAI Coordinator who indicated that she had participated in the resident assessment related to the use of bed rails. She described that for each resident using bed rails that an assessment was done to ascertain if the resident was cognitively able to use the bed rails as a mobility device. She indicated that if the resident was cognitively able, that the rails remained in use. If the resident was not cognitively able to use the rails, the rails would be removed. She noted that where a resident required, other interventions were put in place as they related to the risk of falls (exampled by lowering the bed frame and use of fall mat). To further clarify, the RAI Coordinator said that bed rails were previously used for mobility and/or fall risk, since having completed the assessment of each resident, bed rails are now only in use for mobility; also noting that some bed rails are in use at the preference of the resident and/or substitute decision maker.

The RAI Coordinator identified the Assessment of Assisting Rail document (assessment document) that was used to conduct the resident assessment. The assessment document provides for the following statement:
"Resident (name) has been assessed by the Director of Care, or delegate and RAI-C for criteria of utilization of assisting rail as per Ministry of Health Standards."
Proceeding this statement is the following:
"Resident cited above; meets the requirements for safe use of side rails; Do not meet the requirements of the safe use of side rails."

The RAI Coordinator indicated that either the resident would be identified as meeting the requirements or not meeting the requirements. If the resident met the requirements the bed rail(s) would stay, if the resident did not meet the requirements the bed rail(s) would be removed. She had understood that the requirements included weather or not the resident was cognitively able to use the bed rail. When asked by the Inspector, the RAI Coordinator was not familiar with the HC guidance document or companion documents.

On January 25, 2018, Inspector #148 spoke with the home's DOC regarding the compliance of O.Reg 79/10, s.15. The DOC reported that in consultation with the Professional Advisory Committee, she development the Assessment for Assisting Rail document. The DOC reported that she had completed this assessment documented with all residents with one or more bed rails in use, in December 2017. During a review of the assessment document with the DOC, the DOC reported that she was not familiar with the HC guidance document, however, had a copy of A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment (a companion document to the HC guidance document). She indicated that this guide was not used in the development of the assessment document.

In discussion with the DOC about the content of the assessment document, the Inspector questioned the meaning of "meet the requirements for safe use" and "Ministry of Health standards". The DOC identified the standard/requirement to be that if the resident is unable to use the rail in transfer or positioning then the rail has to be removed as there is a high risk of entrapment. When asked, the DOC could not find where she had identified this statement as a Ministry of Health standard or requirement. In this way, no other factors were considered when the assessment of the resident was conducted.

It was determined that the licensee had not established and implemented a process for the individualized resident assessment in accordance with prevailing practices (2003 FDA Clinical Guidance document). The interdisciplinary team, including the DOC and RAI Coordinator, conducted an assessment of the resident's use of bed rails; no resident assessment was conducted with consideration of factors including: medical diagnosis, conditions, symptoms and/or behavioural symptoms; sleep habits; medication; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling, etc.

The Inspector reviewed the documents provided by the home's DOC related to the resident assessment; in review of these documents and identified resident health care records, the Inspector could not locate a documented risk benefit assessment. The Inspector discussed the concept of a risk benefit assessment with both the RAI Coordinator and DOC, who both indicated that risk benefit assessments were not completed for residents.

During the interview, on January 25, 2018, with the DOC, a document titled Resident Safety devices/Assisting rail/Restraint Checklist was provided to the Inspector. The DOC reported that this document summarized each resident's need for bed rails based on the assessment completed using the Assessment of Assisting Rail document, of which were completed during a one week span in late December 2017. In addition to this document, the DOC provided a document titled Assisting Rail Ready To Be Removed; a document that listed those residents who required one or more bed rails to be removed. It was noted by the Inspector that this document identified at least five residents on a specified unit who were to have two bed rails removed, each of whom had not yet had those rails removed. The DOC indicated that the maintenance personnel was working through the home to ensure that identified bed rails were removed, however, not all had been done.

The Inspector identified the five residents as resident #003, #006, #007, #008 and #009. Each of the five residents were observed on January 24 and/or 26, 2018, to have at least one bed rail in use while the resident was in bed during a rest period. Residents #008, #006 and #004 were observed with two rails in use and residents #009 and #003 with one rail in use. All of the five residents were listed on the Resident Safety Devices document as having no bed rails.

The health care record was reviewed for each of the five residents and the following was noted:
Resident #003 – plan of care indicates the use of bed rail(s), resident attempts to self transfer, fall risk; identified medical diagnosis; Assessment for Assisting Rail document, dated December 2017, indicated that the resident did not meet requirements for the use of bed rails.
Resident #004 – plan of care indicates the resident use of bed rail(s); identified medical diagnosis; Assessment for Assisting Rail document, dated December 2017, indicated that the resident did not meet requirements for the use of bed rails.
Resident #006 – plan of care indicates the resident is dependent on staff for care including bed mobility, bed rails in use, responsive behaviours noted; identified medical diagnosis; Assessment for Assisting Rail document, dated December 2017, indicates that the resident did not meet the requirements for use of bed rails.
Resident #008 – plan of care indicates the resident is dependent on staff for care including bed mobility, bed rails in use, responsive behaviours noted and risk of falls; identified medical diagnosis; Assessment of Assisting Rail

document, dated December 2017, indicates that the resident did not meet the requirements for use of bed rails.
Resident #009 – plan of care indicates the resident is dependent on staff for care including bed mobility, has a fall risk and responsive behaviours; identified medical diagnosis; Assessment of Assisting Rail document, dated December 2017, indicates that the resident did not meet the requirements for use of bed rails.

The licensee completed an assessment of bed rail use, using the Assessment of Assisting Rail document and determined that the above five residents did not use the bed rails and that the rails should be removed. The Inspector reviewed the resident health care records and identified factors that would impact on the entrapment risk of the resident. The Inspector observed these identified rails to remain in use approximately one month after the need for removal was identified by the DOC and RAI Coordinator.

During the interview with the DOC, on January 25, 2018, it was identified that the General Manger was the lead for completion of the bed system evaluations. The Inspector spoke with the General Manager on January 29, 2018. The GM reported that he and a maintenance staff member #122, had conducted the bed evaluations for each resident. He indicated that an external company had provided training to both himself and staff member #122 and had lent them the cone and cylinder tool to conduct the bed system evaluations. Further to this, the GM noted that he had referenced two Health Canada documents, including the HC guidance document and one of the companion documents titled A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment.

Upon further discussion, the GM reported that all bed system evaluations had been completed at the end of October 2017. He was not able to provide any documented bed evaluations to support the completion, but reported that he recalled three bed systems failing at least one zone and that as a result the bed rails on those three bed systems were removed. When asked, the GM was not able to identify the bed system, room or resident involved in these failures or the zones that had failed. Given the observed use of rotating assist rails in the home, the Inspector asked about evaluations/testing completed for intermediate positions, for applicable zones. The GM was not able to confirm that such evaluation/testing had been completed.

It was further shared that a record of a complete inventory of bed systems in the home was not maintained at this time. This was exampled, in that during the competition of bed evaluations, information regarding the bed frame was recorded but not the mattress.

The Inspector conferred with the home's Administrator on January 31, 2018, as to the whereabouts of any documented bed system evaluations. At that time the home could not provide documents to support the completion of bed evaluations.

During the interview with the GM, the Inspector questioned if any of the bed systems in the home had been modified since the bed system evaluations in October 2017. The GM did to believe any modifications has been made as they would be communicated to him; he was aware of maintenance staff removing rails based on the resident assessments completed by the home's DOC.

In review of the Assisting Rail Ready to be Removed document, previously noted in this report, and through discussion with the DOC, it was indicated that where a resident was listed as "remove 1 (left or right)", that these residents had two bed rails in use and that one of the bed rails was to be removed. The same document, identified 18 residents who required a change in current use of bed rails. For most residents it was to have two bed rails reduced to one; three residents were identified as needing a ¾ rail reduced to an assist rail. As indicated by the DOC, decisions to change the number or type of bed rail for a resident was determined in December 2017 when the Assessment of Assisting Rail document was completed (as previously discussed in this report). Of the 18 residents, 13 residents had their existing two bed rails reduced to one bed rail, as maintenance staff had removed the second bed rail in use. The Inspector was able to observe five of these identified residents with one bed rail in use. As confirmed by the GM, bed evaluations were completed in October 2017 and no further evaluations had been completed. The documents reviewed indicate that there were changes to the side rails, however there was no evaluation to ensure that the bed system continued to meet the recommendations of the HC guidance document.

The licensee did not ensure that the bed system evaluations were completed, in accordance with the HC guidance document, specifically related to record keeping of the bed system evaluations and bed system inventory, the

implementation of bed system evaluations (including testing of intermediate positions) and ensuring that bed systems are re-evaluated when there are changes to the bed system.

In accordance with the HC guidance document, the term "entrapment" describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail"

During an interview with the Director of Care, it was indicated that in December 2017, resident #002 had been identified as a resident that does not use the two rotating assist bed rails that were applied to the bed. This was identified by the Assessment for Assisting Rail document, however the rails remained in use at the request of the resident's substitute decision maker. In further discussion about this resident, the DOC reported that the resident moves a lot in bed and was found caught at the top of the bed with his/her upper body out of the bed. The Inspector later reviewed the home's incident report of a specified date and spoke with RN #118 and PSW #121 who were present at the time of the incident. PSW #121, who had discovered the resident indicated that during rounds, she entered the bedroom of resident #002 and observed the resident half off the bed, including the resident's upper body, head, neck and breast over the bed. Upon further description the PSW noted that the resident's night clothes were tight around the resident's neck; no signs of distress were noted. The PSW proceeded to reposition the resident back into bed, providing extra pillows for positioning and reported the incident to RN #118. PSW #121 confirmed that the resident had two bed rails in use at the time and that the resident's lower torso and legs were held in the bed by the bed rail, while the upper body was hanging off the side of the bed.

Resident #002 was admitted on a specified date with diagnosis that would affect mobility. The current plan of care notes the resident's dependence on staff for activities of daily living, behaviours and decline in cognition. Upon review of the resident's health care record, a progress note dated one day after the entrapment incident, indicated that padding would be applied to the bed rails. A subsequent progress note three days after the incident, indicates that a discussion had taken place with the resident's substituted decision maker and that the bed rails were to be removed.

Inspector #148 observed resident #002 in bed on January 24, 25 and 26, 2018,

with two rotating assist rails in the horizontal position (one rail on each side of the bed, located at mid length of the bed) with padded cover on both bed rails. At the time of observation the bed rails had not yet been removed and were still in use for resident #002.

The licensee did not ensure that a resident assessment for resident #002 was conducted, in accordance with prevailing practices; nor can the home demonstrate that the bed system was evaluated in accordance with best practice, as referenced above earlier in this report. After the incident, as described above, steps were not taken to prevent resident entrapment, taking into consideration all potential zone of entrapment.

Over the course of this inspection it was noted that several residents have various bed rails in use, predominately rotating assist rails, indicating that this non-compliance affect many residents in the home and is widespread. It was determined that residents who were identified in December 2017 to not use rails continue to have such rails in use and that evidence collected during this inspection indicates that both the resident assessment and bed system evaluations were not conducted in accordance with the HC guidance document. Additionally, an entrapment incident was identified to have occurred, subsequent to the entrapment incident identified in the grounds of CO #002 (RQI report of 2017). Such indicates that this non-compliance presents actual harm with previously identified non-compliance. The scope, severity and compliance history support the issuance of this Compliance Order. (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 11, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_619550_0015, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration;
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;
(d) includes alternative beverage choices at meals and snacks;
(e) is approved by a registered dietitian who is a member of the staff of the home;
(f) is reviewed by the Residents' Council for the home; and
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

Order / Ordre :

1. Develop and implement menus for regular, therapeutic and texture modified diets for both meals and snacks.

2. Ensure that the menus are accompanied with production sheets and standardized recipes to ensure the nutritional adequacy of the implemented menu.

3. Develop and implement guidelines for the implementation of nutritional interventions; including small portions, 1.5 portion and weight reducing therapeutics.

4. Ensure that the planned menu and planned nutritional interventions are offered to residents, including alternative choices of entrees, vegetable and desserts at lunch and dinner.

Grounds / Motifs :

1. The licensee failed to ensure that the home's menu cycle includes: menus for regular, therapeutic and texture modified diets for both meals and snacks and alternative choices of entrees, vegetables and desserts at lunch and dinner.

On June 23, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 71 as a result of Resident Quality Inspection (RQI) #2017_619550_0015. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by August 18, 2017.

The licensee was ordered, in part, to take the following action:
The licensee shall ensure that menu planning includes:
1. Menus for texture modified diets for both meals and snacks
2. The meal menu shall include alternative pureed choices of entrees, vegetables and desserts at lunch and dinner
3. The snack menu shall include a pureed snack option in the afternoon and evening
4. Offering each resident a minimum of three meals daily.

On January 24, 2018, the Inspector spoke with the home's RD/NM, who had been recently hired in the fall of 2017. The RD/NM was aware of the outstanding Compliance Order and applicable legislative requirements. She indicated that upon her arrival to the home she noted several concerns with the dietary program that required attention. She reported that among other items, she developed a four week menu with specific changes to improve nutritional quality. In addition, she had purchased new equipment including dining room tables, made changes to the meal times, implemented course by course service and reviewed the program as it related to food safety and staff training.

Upon the Inspector's review, it was confirmed that the RD/NM had developed a four week menu for three meals and between meal snack and beverages for the regular diet, regular texture. At the present time she had completed most work for the Week 1 therapeutic menu, which includes a menu for puree and minced texture modifications at meals. The therapeutic menu was not yet implemented for staff use. In addition, the RD/NM had developed production sheets for Week 1 and 2 of the menu. At this time there were no therapeutic menus for Week 2, 3 and 4 for the meals and no therapeutic menus developed for Week 1, 2, 3 and 4 for the snack menu. It was reported by the RD/NM that with the lack of therapeutics in place at this time, it was expected that staff follow the regular

menu in the production of other therapeutic diets, such as the minced and puree texture modifications.

The Inspector observed the lunch meal service on January 24, 2018 and January 25, 2018 along with the breakfast meal service on January 25 and 26, 2018. The following were noted by the Inspector:
-On the first meal observation of January 24, 2018, there was one choice of puree vegetable. When the regular full time Cook #104, who was responsible to serve the lunch meal, was asked about the puree vegetable choice, he noted he is only required to make one puree vegetable at meals.
-During observations of the meals and snacks, the Inspector noted items such as pancakes, muffins, fruit and cookies as planned by the regular menu, were not prepared for the puree texture modification.
-On several occasions including the lunch on January 24, breakfast on January 26 and snack service on January 25, the dietary staff used leftover food items from previous meals to provide the dessert choice, fruit and snack, respectively. FSW #105 and FSW #110, who prepare such items for the puree modification, noted that leftovers are used to prepare the puree items when available from a previous meal. Both identified that they did not have a therapeutic menu to follow in the production of puree textured items.
-During the afternoon snack, PSW staff serving the snack, including PSW #106, indicated that the cookies available on the cart were appropriate for the minced texture, whereas PSW #107 indicated that she would serve the banana to those residents on minced texture. PSW staff serving the snack were not clear on the food items appropriate for residents on texture modified diets. Both identified that they did not have a therapeutic menu to follow in the service of the minced items.
-During the lunch meal service of January 24 and 25, 2018, the Inspector noted that the puree textured food items were smooth, however, did not hold shape and had wide spread on the plate. In addition, it was noted that the portion size appeared reduced. It was observed that at each meal, the #16 scoop was consistently used for all puree and minced textured items along with the mashed potatoes.

As noted earlier in the report the staff producing and serving food did not have therapeutic menus to guide the production or provision of food items outside of the regular diet, regular texture. In review of the production sheets and available recipes, there were no directions to staff on the implementation of the puree and minced texture modified therapeutics; the staff did not have guidance in place

related to scoop size (portion size) to use for meal service. As noted earlier, the staff serving the meal primarily used the #16 scoop; in review of standardized portions and the Week 1 therapeutic developed by the RD/NM, the planned scoop size for puree and minced items will be #12 and #10, with #8 for items such as mashed potato. Upon further review of the production program, it was noted that at this time there were no available recipes for the production of puree or minced texture modified items. Staff were not provided with guidance on the production of puree texture food items to ensure consistency of such products are reached (exampled by no lumps/holds shape).

In review of the Cardex, a document listing each resident in the home along with their diet, texture and nutritional interventions, it was noted by the Inspector that three residents were listed to require 1.5 portion size, four residents were identified to require small portion size and two residents were identified to require weight reducing diets. During interviews with Cook #104 and Cook #109, both of whom serve lunch meal service, the staff members had various interpretations of these nutritional interventions. The Cook staff members were not clear if all food items were reduced with the small portion size or what this portion size would be. Cook #104 could not identify any difference in the meal service for a resident listed to require 1.5 portions and the regular diet, nor could he identify any difference in the meal service for a resident listed to require weight reducing and the regular diet. At this time staff are not clear on the implementation of such nutritional interventions/therapeutic diets. The same was discussed with the RD/NM on January 30, 2018, to which the RD/NM confirmed there to be no planned therapeutic or other reference for staff to follow for these noted interventions.

At this time the home does not have a menu cycle that includes a planned menu for all therapeutics and texture modifications in the home, including such therapeutics for portion variations and weight reducing. The lack of development of menus, production sheets and recipes affect a wide scope of residents in the home with a potential risk of harm. In addition, the home has had a previous Compliance Order, as indicated in these grounds. The scope and compliance history support the issuance of this Compliance Order. (148)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 11, 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 6th day of February, 2018

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