Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 12, 2019	2018_765541_0017 (A2)	026518-18	Resident Quality Inspection

Licensee/Titulaire de permis

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Amended by AMBER LAM (541) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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The following change was made to the Order report:
- Compliance Order #002 due date was extended from March 30, 2019 to April 30, 2019.

Issued on this 12nd day of March, 2019 (A2)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Amended by AMBER LAM (541) - (A2)

Amended 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): October 9-12, 15-19 and 22-24, 2018

The following logs were completed concurrently with this inspection:

Log #016964-18 (Critical Incident #2640-000005-18) related to a fall with a significant change in condition

Log #027150-17 (Critical Incident #2640-000011-17) related to an alleged staff to resident abuse/neglect

Log #016962-18 (Critical Incident #2640-000002-18)related to an alleged staff to resident abuse/neglect

Log #016954-18 (Critical Incident #2640-000003-18) related to an alleged staff to resident abuse/neglect

Log #016971-18 (Critical Incident #2640-000008-18) related to a fall with a significant change in condition

Log #027276-18 (Infoline #IL-60820-OT) related to a fall with a significant change in condition

Log #027451-18 (Critical Incident #2640-000009-18) related to a fall with a significant change in condition

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Resident and Family Services manager, Registered Nurses (RN), Registered Practical Nurses (RPN), a physiotherapist, a maintenance staff member, a scheduling clerk, a receptionist, staff from the Mobile Response Team (MRT), Personal Support Workers (PSW), the Family Council President, the Residents' Council President, residents and family members. In addition, the inspectors also conducted a tour of the home, observed a resident meal service, observed a medication administration, and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **11 WN(s)**
- **7 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 has been assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the residents, and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In August, 2012, 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 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. 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, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used.

Related to the evaluation of residents' bed systems, where bed rails are used, in accordance with evidence-based practices to minimize risk to the residents:

The following was observed during the inspection period:

Resident #008 – 2 x ¾ rails up while resident in bed
Resident #020 – 1 x ¾ rail and 1 x ¼ rail up while resident in bed

Resident #049 – 2 x ¾ rails up while resident in bed

Residents #008, #020 and #049's health care records were reviewed and there was no documentation found to support the completion of an individualized resident assessment to assess the risk of using the bed rails or that the bed systems belonging to resident #008, #020 and #049 had been evaluated in accordance with prevailing practices, in order to minimize risk to the resident.

Physiotherapist #111 was interviewed on October 11, 2018 related to bed rail assessments and stated that in the summer of 2018 they had gone through all the bed rails in the home to ensure that the information captured in POC (Point of Care) was accurate for each resident. They stated that they had not completed any other assessments related to the use of bed rails in the home.

The Director of Care was interviewed related to bed rail assessments and indicated that if they could not be found in the resident's paper or electronic charts then they have not been completed.

Related to steps being taken to prevent resident entrapment, taking into consideration all potential zones of entrapment:

During the inspection period, Resident #020 was noted to have 1 ¼ bed rail in place. Zone 1, the open space within the perimeter of this rail, was noted by the inspector to exceed 120 mm (4 ¾ inches). Health Canada recommends a measure of less than 120 mm (4 ¾ inches) as the dimensional limit for any open space within the perimeter of a rail.

Interviews with the Physiotherapist #111 and staff on the unit, indicated that the resident had brought this ¼ bed rail from home and it had been in place since their admission.

The Maintenance Manager #125, who completed the bed system evaluations, informed the inspector that the last evaluation of bed systems in the home was May 2017 and that they had not evaluated resident #020's bed system with the 1 ¼ rail they had brought from home.

The Maintenance Manager provided the inspector with a copy of the results from the May 2017 bed system evaluation. The evaluation indicated that there were 33 bed systems at that time that failed in at least one zone of entrapment. The

Maintenance Manager indicated that of these 33 bed systems that failed, 4 currently remain in use by residents #017, #018, #051 and #052. They further stated that there had been no steps taken to prevent resident entrapment with respect to these remaining 4 beds.

The licensee has failed to ensure that where bed rails are used, residents #008, #020 and #049 were assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the residents. The licensee also failed to ensure that where bed rails are used, that steps are taken to prevent resident entrapment for residents #017, #018, #020, #051 and #052, taking into consideration all potential zones of entrapment. [s. 15. (1) (a)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with 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. (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 plan of care for resident #047 set out clear directions to staff and others who provide direct care to the resident.

Resident #047 was admitted to the home on a specified date.

The "Admission Resident Profile and Assessment" form was completed by RN #112 with assistance from the resident's family members. This assessment included information about resident #047's transfer and mobility status.

A hand written, 8 ½ by 11 sheet of paper with no date and no signature was also noted to be in resident #047's paper chart, which indicated further information about resident's ambulation, fall risk and mood.

During an interview with RN#112, they stated that resident #047 was asleep in their wheelchair with a specified fall prevention intervention in place during the initial admission. They stated the family said this was the resident's normal state. The RN asked the family if the resident could walk and they said the resident could walk, but with assistance. The RN also recalled having a discussion with the family about the resident having two other specified fall prevention

interventions in place while in bed. When asked if there was discussion during admission with the family about other specified fall prevention interventions, they stated they recalled this being brought up but did not document that part of their conversation.

In a phone interview with one of resident #047's family members, they stated that during admission they emphasized to staff that the resident requires two specified fall prevention interventions in place.

Upon review of resident #047's paper chart, the inspector noted that there was a consent form paper-clipped to the outside of the chart for the use of two specified fall prevention interventions, dated on admission, that had not yet been signed.

The inspector also noted that a Restraint Initial Assessment had been completed for resident #047 in PointClickCare the date the resident was admitted. This assessment stated reasons for the specified restraint and listed contributing factors. The inspector noted that another specified fall prevention intervention was not checked in this assessment.

The first evening the resident was in the home, RPN #116 charted that the resident was agitated, was self-transferring and walking independently. The resident was also noted to become aggressive with staff when intercepted.

The day following resident #047's admission RPN #117 and RPN #118 charted that the resident exhibited agitation, wandering and exit seeking behavior and was walking without using their wheelchair. On the same date, the Resident and Family Services Manager (RFSM) #119 also charted requesting assistance from an outside agency to assist in transitioning resident #047 to the home.

On October 22, 2018, the RFSM indicated in an interview that when they spoke to the family of resident #047 they would have stated the outside agency was to help with the transition to the home and to help the resident settle and no other care specific details were discussed related to the resident's care and/or behaviours.

The day following resident #047's admission, RPN #120 charted that resident #047's gait was unsteady arising from a chair and that the resident was assisted into their wheelchair with effect.

Two days following resident #047's admission, the resident was noted by RN

#121 to be attempting to self-transfer into chairs.

RPN #117 was interviewed at approximately 1300 hours on October 22, 2018. They stated that resident #047 would often move around, remove one of the specified fall prevention interventions and would walk without assistance and wander. They stated that staff tried to keep an eye on the resident as much as they could. RPN #117 stated that another specified fall prevention intervention was put in place at some point but they could not recall it working. They thought maybe the resident removed the specified intervention. They recalled the resident having another specified fall prevention intervention, which would be in place and then next thing staff knew the resident would be up and walking again. They stated they would redirect the resident to their wheelchair and reapply the specified fall prevention intervention. RPN #117 stated that they communicated pertinent information to the RN on the shift and also give this information at shift report to PSWs and the oncoming RPN. They stated there is also a written shift report, which they believe is kept and filed.

Inspector #197 requested copies of the shift report sheets from the Director of Care for three specified dates for the wing where resident #047 resided. Shift report sheets for two dates were provided and there were no notes on the shift report sheets to indicate the use of any of the noted specified fall prevention interventions, the fact the resident could remove one of the specified fall prevention interventions or any contact with the resident's family to discuss the resident's care.

On a specified date and time, RPN #122 charted that resident #047 was up early that morning and wandering. They noted that the resident required frequent monitoring and redirection due to wandering. The resident was also noted to be removing one of their specified fall prevention interventions and self-propelling in their wheelchair. On the same specified date, RPN #122 also noted that there was a team member from an outside agency in at the time working one-on-one with resident #047. The RPN also documented a conversation with the resident's family at this time but there was nothing related to the resident's specified fall prevention interventions, consent for a fall prevention intervention to be signed or the resident's recent behaviours. At a later time on the same specified date, RPN #116 documented that resident #047 had an unwitnessed fall in another resident's room and was sent to the hospital for further assessment.

During an interview with RPN #116, they stated that they were working the first

evening shift after the resident was admitted on a specified date. RPN #116 said the resident was very agitated and was walking independently without issue. Staff saw this and rushed to assist the resident. They stated that staff was under the impression at first that resident #047 could not remove a specified fall prevention intervention but they witnessed the resident remove the specified intervention very easily. The RPN noted that the resident was agitated with staff, was exit seeking and wandering.

RPN #116 stated that their next shift in the home was when the resident fell. At the beginning of RPN #116's shift, resident #047 had an unwitnessed fall. RPN #116 could not say whether the resident had a specified fall prevention intervention applied just before the fall since this was the first time seeing the resident on the shift. When asked if the resident had a specified fall intervention in place, they stated they were unsure and did not know of the specified intervention being used for resident #047.

PSW #123 who works with an external program, was interviewed and stated that they were in the home with the resident for approximately one hour just prior to the resident #047 falling. They indicated they were in the home at the time of the fall but with another resident. They stated that resident #047 did not have a specified fall prevention intervention in place at the time of their visit, although noted the resident did have one present. They stated they were told by RPN #116 that the resident could remove the specified fall prevention intervention.

PSW #124 who also works with an external program, was also interviewed since they worked with resident #047 on two specified dates prior to the fall. On both days, they indicated that the resident did not have a specified fall prevention intervention in place since the consent had not been signed. They also could not recall any other specified fall interventions being in place for resident #047. They stated that on one of the specified dates, they did not recall the resident having a specified fall prevention intervention in place while in bed, but the resident did have another in place.

Two PSW's (#126 and 127) that worked the date that resident #047 fell, were interviewed. PSW #126 stated that they worked the first shift the resident was admitted, assisted them to bed and noted that shortly after, the resident was up wandering. They recalled the night staff implementing a specified fall prevention intervention and the next time they saw the resident they had the specified intervention in place.

PSW #127 stated that staff were told the resident could not walk and was a two-person transfer when they were first admitted. They stated that the resident could walk and could also get out of bed even when a specified fall prevention intervention was in place. They said that they would sit the resident down in their wheelchair and had asked the RPN if it was ok to apply a specified fall prevention intervention but was told they could not. The PSW could not recall who told them the intervention could not be used for resident #047. PSW #127 went on to say the next day they worked in the home, the resident did have the specified fall prevention intervention in place, but was told the resident could remove it. They stated when they left the home following their shift on the date prior to the fall, the resident was in their wheelchair but no specified fall prevention intervention was in place.

PSW #100 worked on two specified dates prior to the resident's fall. The PSW said that over the course of the two days they never saw the resident in their wheelchair. They said the resident was up and walking constantly and seemed quite steady on their feet. PSW #100 stated that there was one other specified fall intervention in place and they thought there may have been a second specified fall prevention intervention in place but could not recall for sure since they never saw the resident in their wheelchair.

RPN #129 that worked the day shift on the date resident #047 fell was interviewed and indicated this day was the first time they had met resident #047. They reviewed their progress notes that were made and recalled that there was some discussion about how the resident could remain safe. They also indicated that they were aware that the family wanted everything in place to keep the resident safe and listed three specified fall prevention interventions in place for the resident. RPN #129 indicated they did not recall another specified fall prevention intervention being implemented for resident #047 but did recall that there was some discussion about it.

During interviews with the Director of Care (DOC), they stated that they had not spoken to resident #047's family in the three days after the resident was admitted and prior to the fall to discuss the resident's care. They stated that their expectation of staff in this type of situation would have been to get additional support and do more one-to-one care. They also stated they would have expected staff to discuss the resident's care with the family. The DOC stated that if new interventions were being put into place for a resident, the charge nurse

would discuss at report, the RPN would then discuss with the care team and they would also expect that there would be documentation in the progress notes.

According to the admitting RN and the family of resident #047, three specified fall prevention interventions were discussed for the resident. The consents for two of the specified fall prevention interventions dated on the resident's admission were not signed. The Restraint Initial Assessment indicated a specified fall prevention intervention was required, but not another specified intervention and the inspector could not find any documentation in the resident's paper or electronic chart related to the use of a third specified fall prevention intervention. Interviews with multiple staff members including RN's, RPN's and PSW's demonstrated that the three fall prevention interventions discussed at admission were not consistently in place over the time the resident was in the home and some staff were unsure if one of the specified fall prevention intervention could be used. Therefore, the plan of care for resident #047 did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that a resident's substitute decision-maker (SDM) and the designate of the resident/SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #047 was admitted to the home on a specified date. During the admission, the resident's family and the RN discussed three specified fall prevention interventions to be put into place for the resident.

Progress notes from the time the resident was in the home, showed multiple instances where the resident was able to remove one of the specified fall prevention interventions and ambulate throughout the home. Staff interviews indicated that the resident's behaviour was quite different than how they presented at admission and that they were able to get out of bed even with another specified fall prevention intervention in place and that the resident was able to remove a third specified fall prevention intervention and ambulate.

Resident #047 had an unwitnessed fall on a specified date and was sent to hospital, where it was determined that they had sustained an injury from the fall.

The family of resident #047 indicated to the inspector that they had not been contacted about the fact that the resident could undo a specified fall prevention intervention and was ambulating around the home.

Review of the resident's health care record and staff interviews showed no evidence that the family had been contacted and the care of resident #047 discussed before the resident's fall on October 6, 2018. [s. 6. (5)]

3. 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.

Inspector #641 reviewed a critical incident related to an alleged abuse of resident #036 that occurred on a specified date.

During an interview with Inspector #641 on October 16, 2018 at 1140 hours, the Director of Care (DOC) indicated that on the morning of the incident on the specified date, the PSW who was working on nights had gone into resident #036's room and conducted care with the resident independently, when the resident had been identified as requiring two persons for all care. During the care, the PSW had pushed the resident into the bedrail causing an injury. The DOC advised that the PSW should not have administered care to the resident until another staff member was available to assist.

During an interview with Inspector #641 on October 18, 2018 at 1330 hours, PSW #110 indicated that resident #036 required two staff for all care. The PSW advised that the resident was totally dependent on staff for care and if the resident required to be changed, there would be two staff needed to change the resident. When asked, the PSW indicated that they would never do care on resident #036 on their own since the resident was care planed as requiring two persons for all care.

The licensee failed to ensure that resident #036 was provided care as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that seat belts were applied in accordance with the manufacturer's instructions.

On a specified date, resident #021 was observed sitting a wheelchair with a front closing seat belt applied. It was noted by Inspector #541 that the belt appeared loose and could be pulled 3-4 inches away from the resident.

On a specified date, resident #045 as observed sitting in a wheelchair with a front closing seat belt applied. It was noted by Inspector #541 that the belt appeared loose and could be pulled 5-6 inches away from the resident. The Director of Care (DOC) was present at the time the inspector observed resident #045's seat belt and the DOC confirmed the belt was not applied appropriately.

On another specified date, resident #045 was again observed in a wheelchair with a front closing seat belt applied and it could be pulled 2-3 inches away from the resident.

On another specified date and time, Inspector #197 observed resident #049 in front of the nursing station by the large dining room sitting in a wheelchair with a seat belt done up very loosely with the buckle hanging below the residents knees.

Manufacturer's instructions for the front closing seat belts were provided to Inspector #541 by Physiotherapist #111. The document is titled "Pelvic Support User's Guide" by Bodypoint. The instructions stated that the belt it to be kept tight during fitting and maintain this tightness during daily use to ensure correct placement. For non-paddded hip belts, the adjustment strap at the buckle should be approximately 4-6 inches long. It further stated that "teaching the caregiver techniques is essential for correct hip belt positioning."

Residents #021, #045 and #049 did not have their seat belts applied according to the manufacturer's instructions. [s. 23.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that during the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection 8 (3) of the Act.

Inspector #541 reviewed the Registered Nurse (RN) schedule for a one month period provided to the inspectors upon entrance to the home. A review of the schedule from September 29 - October 26, 2018 indicated there were 6 RN shifts not filled. Inspector #541 obtained the Daily Assignment Sheets which reflect which staff member worked during each shift. It was noted the Director of Care (DOC) worked as the charge RN on September 27, September 30, October 3, October 8 and October 12, 2018.
It was also noted the DOC was not in the building on October 9, 10 and 15, 2018 and staff stated it was due to working as the RN in charge the night prior.

During an interview with Inspector #541, the DOC indicated having to complete DOC duties while working as the charge RN. [s. 8. (4)]

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 during the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations,, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that an entrance to a non-residential area was not kept locked when it was not supervised by staff.

During the initial tour for the home on October 9, 2018 at approximately 0945 hours, inspector #197 entered an unlocked, outdoor patio area that is accessible to residents. When walking around the area, the inspector noted that their was a gate that leads to a non-residential area behind the home. At the time of the observation, it was noted that the gate was kept closed with a chain and there was a pad lock attached to the chain that was not locked, giving residents the ability to leave the outdoor area and potentially exit the home/property. There were no staff in the area at the time of the observation.

The Maintenance Manager was called, staff member #125, and accompanied the inspector to the outdoor patio area. They were surprised to see that the gate was not locked and indicated that likely the person who comes to mow the lawn over the weekend had forgotten to secure the gate. They further stated that they will typically check all locks each morning, but had not had a chance to do this yet since it had been a busy morning. The Maintenance Manager secured the lock before leaving the outdoor area. [s. 9. (1) 2.]

2. The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

On October 17, 2018, the Maintenance Manager was asked if the home had a written policy related to their outdoor area that is currently accessible to residents. They indicated that the home does have guidelines for when the doors to this area are to be locked and unlocked, but was unsure if these guidelines were in writing.

The Maintenance Manager came back a short time later and confirmed that the home did not currently have a written policy that deals with when the doors to the outdoor area are to be locked and unlocked. [s. 9. (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 all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff and to ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include 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; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written staffing plan for the nursing and personal support services programs.

During an interview with Inspector #641 on October 16, 2018 at 1530 hours, the Director of Care (DOC) indicated that the home does not have a written staffing plan. The DOC advised that they would work on writing up a staffing plan and submit it to the Inspector in the morning. At 1125 hours on October 17, 2018, Inspector #641 received from the DOC, the "Nursing Staffing Plan for Sherwood Park Manor" and was advised that it had just been completed.

During an interview with Inspector #641 on October 17, 2018 at 1620 hours, the Administrator (Admin) indicated that the home did not have a written staffing plan. The Admin advised that they considered the staffing schedule to be their plan and there had been nothing written specifically documenting a formal staffing plan which would include a back-up plan for replacing staff. The Admin clarified that the DOC had written up the document entitled the Nursing staffing Plan for Sherwood Park Manor that morning for the Inspector, indicating what the home followed related to staffing and how they replaced their staff call-ins.

The licensee failed to ensure that there was a written staffing plan for the nursing and personal support services programs. [s. 31. (2)]

2. The licensee failed to ensure that the staffing plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During an interview with Inspector #641 on October 17, 2018 at 1620 hours, the Administrator (Admin) advised that there was no evaluation tool with respect to the staffing plan or documentation relating to an annual evaluation of the staffing plan. The Admin indicated that the managers talk about staffing in their management meetings as it related to the budget, but there was no specific documentation of an evaluation of the staffing plan.

The licensee failed to ensure that the staffing plan was evaluated and updated at least annually.

It is noted the evidence gathered for this non-compliance was obtained by

Inspector #641. [s. 31. (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 there is a written staffing plan for the nursing and personal support services programs and that the staffing plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD described in subsection (1) that is used to assist a resident with a routine activity of living is included in the residents' plan of care.

Resident #045 was observed on October 18, 2018 sitting in a wheelchair that was tilted. An interview with Physiotherapist #111 indicated the resident has a tilt wheelchair for positioning. Physiotherapist #111 further stated that if the resident tried, the resident would be able to get up from the wheelchair if it were not tilted.

A review of resident #045's care plan, restraint assessments, physiotherapy assessments and progress notes did not indicate that resident #045 is to use a tilted wheelchair. [s. 33. (3)]

2. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #045 was observed on October 18, 2018 sitting in a wheelchair that was tilted. An interview with Physiotherapist #111 indicated the resident has a tilt wheelchair for positioning. Physiotherapist #111 further stated that if the resident tried, the resident would be able to get up from the wheelchair if it were not tilted.

Inspector #541 reviewed the PASD consent forms for resident #045 and there was no consent found for a tilt wheelchair. Physiotherapist #111 confirmed that tilt wheelchairs have not been included on the PASD or restraint consent forms. The licensee failed to ensure that resident #045's tilt wheelchair has been consented to by the resident or, if the resident is incapable, a substitute decision-maker. [s. 33. (4) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care and use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the Director was informed within one business day after the occurrence of an incident that causes an injury for which the resident was taken to hospital and that results in a significant change in the resident's health condition.

On a specified date and time, resident #048 fell while walking with a walker. The resident was assessed, noted to be in pain and subsequently sent to hospital. According to a progress note entered at a later specified time on the same specified date, the home was notified by the hospital that resident #048 would be admitted with a specified injury. The Director was not notified of the critical incident until two days after the home becoming aware of resident #048's injury.

The DOC confirmed during an interview with Inspector #541 that the CI was submitted late and stated it was related to an issue with accessing the system due to being relatively new to the home. [s. 107. (3) 4.]

2. On a specified date and time, resident #047 had an unwitnessed fall in another resident's room. The resident was assessed by staff and sent to the hospital, where they were noted to have an injury. According to the progress notes for resident #047, the home was aware of the resident's injury at at a later time on the same date the resident fell.

The home notified the Director of the resident's fall and fracture via Critical Incident Report 3 business days after the incident occurred. [s. 107. (3) 4.]

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 ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

WN #9: 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 :

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

Inspector #641 reviewed a medication incident for resident #044 for a specified date. The report indicated that resident #044 had a physician's order for a specified medication to be given at a specified time. The resident was out on a leave that evening, not returning to the building until three hours after the time the medication was scheduled for. A progress note in the resident chart for the specified date, indicated that the information would be passed on to the next shift that the resident had not received the specified medication The incident report noted the next morning that the specified medication was on the cart not given. A review of the resident's medication administration record (MAR) indicated that on the specified date, the specified medication had not been signed that it had been given. The medication incident documented that there was no harm to the resident.

During an interview with Inspector #641 on October 16, 2018 at 1140, the Director of Care (DOC) indicated that they were aware of the medication incident and that the specified medication had not been given to the resident as ordered.

The licensee failed to ensure that resident #044 was administered medication in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review are implemented; and that a written record is kept of everything provided for in clause (a) and (b).

During an interview with Inspector #641 on October 16, 2018 at 1140, the Director of Care (DOC) advised that the medication incidents were supposed to be reviewed by the pharmacy and brought to the Pharmacy and Therapeutics meetings, but the pharmacist had not been consistently doing this. The DOC clarified that they had not been reviewing the incidents for any trends to this point. The DOC indicated that they had started in the position as DOC in May 2018 and that there had not been a Professional Advisory Meeting since before they had started, but that there would be one occurring in the next few weeks. Inspector #641 requested from the DOC the minutes of all the Pharmacy and Therapeutics' meetings for the past year.

Inspector #641 reviewed the minutes of the Pharmacy and Therapeutics' committee meetings from November 28, 2017 to October 2, 2018. There had been four meetings during this time period: November 28, 2017, March 27, June 28 and October 2, 2018. A review of the November 28, 2017 minutes included a

list of the medication incidents for the previous quarter but there was no documentation of the incidents being reviewed, trended and or changes made related to this. A review of the March 27, 2018 minutes indicated that medication incidents had been on the agenda. There were two entries under medication incidents, one related to faxing incident reports to the pharmacy and another related to staff training for online reporting of incidents. There was no documentation in the minutes related to a review of the medication incidents that had occurred in the home in the previous quarter. Included in the minutes was a pharmacy memo to the DOC, Administrator and Nursing staff dated March 2018 reviewing the updates to the medication incident reporting (MIR) including how to generate reports for trending types of medication incident to help with preventative and corrective action in the home. There was no documentation of a review of the medication incidents from the last quarter in the June 28, 2018 meeting minutes. There were no minutes for the October 2, 2018 meeting. The agenda did not list that a review of medication incidents would be part of the meeting.

The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions. [s. 135. (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, (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Inspector #641 reviewed a critical incident report which indicated that during on a specified date, PSW #130 had completed care on resident #036 independently instead of with a partner, as directed by the resident's care plan. During the care, resident #036 received a specified injury. The resident's POA had been notified after the incident as well as the physician and the Director of Care. The incident relating to improper care of resident #036 was not submitted to the Director until eight days after the incident occurred.

During an interview with the Inspector on October 16, 2018 at 1140, the Director of Care (DOC) indicated being aware that the critical incident had been submitted late.

The licensee failed to ensure that the critical incident related to improper care of resident #036 was reported immediately to the Director. [s. 24. (1)]

Issued on this 12nd day of March, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMBER LAM (541) - (A2)
Inspection No. / No de l'inspection :	2018_765541_0017 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	026518-18 (A2)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 12, 2019(A2)
Licensee / Titulaire de permis :	Sherwood Park Manor 1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1
LTC Home / Foyer de SLD :	Sherwood Park Manor 1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Alfred O'Rourke

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Sherwood Park Manor, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 must be compliant with O. Reg. 79/10, s. 15 (1).

Specifically the licensee shall:

1) Ensure that bed rail use for resident #008, #020, #049 and any other resident is assessed and implemented in full accordance with 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). This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment, following the resident assessment

by the interdisciplinary team, where bed rails are in use. The documented risk benefit assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion, if bed rails are used, indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

c) Documented approval of the use of bed rails for an individual resident by the interdisciplinary team that conducted the resident's assessment and the final risk benefit assessment. The names of the team members are to be documented.

2) Ensure that steps are taken and documented to prevent resident entrapment for residents #017, #018, #020, #051, #052 and any other resident, taking into consideration all potential zones of entrapment.

3) Update the written plan of care based on the resident's assessment/reassessment by the interdisciplinary team. Provide clear directions as to how the bed rails on a resident's bed are to be used, when they are to be used, and in what position they are to be used. 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. 1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the residents, and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In August, 2012, 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 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. 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, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used.

Related to the evaluation of residents' bed systems, where bed rails are used, in accordance with evidence-based practices to minimize risk to the residents:

The following was observed during the inspection period:

Resident #008 – 2 x ¾ rails up while resident in bed
Resident #020 – 1 x ¾ rail and 1 x ¼ rail up while resident in bed
Resident #049 – 2 x ¾ rails up while resident in bed

Residents #008, #020 and #049's health care records were reviewed and there was no documentation found to support the completion of an individualized resident assessment to assess the risk of using the bed rails or that the bed systems belonging to resident #008, #020 and #049 had been evaluated in accordance with prevailing practices, in order to minimize risk to the resident.

Physiotherapist #111 was interviewed on October 11, 2018 related to bed rail assessments and stated that in the summer of 2018 they had gone through all the bed rails in the home to ensure that the information captured in POC (Point of Care) was accurate for each resident. They stated that they had not completed any other assessments related to the use of bed rails in the home.

The Director of Care was interviewed related to bed rail assessments and indicated that if they could not be found in the resident's paper or electronic charts then they have not been completed.

Related to steps being taken to prevent resident entrapment, taking into consideration all potential zones of entrapment:

During the inspection period, Resident #020 was noted to have 1 ¼ bed rail in place. Zone 1, the open space within the perimeter of this rail, was noted by the inspector to exceed 120 mm (4 ¾ inches). Health Canada recommends a measure of less than 120 mm (4 ¾ inches) as the dimensional limit for any open space within the perimeter of a rail.

Interviews with the Physiotherapist #111 and staff on the unit, indicated that the resident had brought this ¼ bed rail from home and it had been in place since their admission.

The Maintenance Manager #125, who completed the bed system evaluations, informed the inspector that the last evaluation of bed systems in the home was May 2017 and that they had not evaluated resident #020's bed system with the 1 ¼ rail they had brought from home.

The Maintenance Manager provided the inspector with a copy of the results from the May 2017 bed system evaluation. The evaluation indicated that there were 33 bed systems at that time that failed in at least one zone of entrapment. The Maintenance Manager indicated that of these 33 bed systems that failed, 4 currently remain in use by residents #017, #018, #051 and #052. They further stated that there had been no steps taken to prevent resident entrapment with respect to these remaining 4 beds.

The licensee has failed to ensure that where bed rails are used, residents #008,

#020 and #049 were assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the residents. The licensee also failed to ensure that where bed rails are used, that steps are taken to prevent resident entrapment for residents #017, #018, #020, #051 and #052, taking into consideration all potential zones of entrapment. [s. 15. (1) (a)]

The decision to issue this non-compliance as a compliance order was based on the following:

The severity of this non-compliance is a level 2 (Potential for Harm/Risk) as there is potential harm/risk to residents if their bed rails have not been assessed and steps have not been taken to prevent resident entrapment on specified bed systems.

The scope of this non-compliance is determined to be a level 2 (pattern) as it affects multiple residents in the home.

The home has a level 2 compliance history (1 or more unrelated non-compliances in the last 36 months).
(197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with LTCHA 2007, s. 6 (1).

Specifically, the licensee shall ensure that the plan of care for resident #047, and any other resident, in relation to falls prevention, sets out clear directions to staff and others who provide direct care to the resident by ensuring:
1) Consistent information throughout the plan of care that is understood and followed by direct care staff.
2) Documented consent by the resident or their Substitute Decision Maker for fall prevention interventions, where required
3) Revisions are based on the reassessment of a resident's condition/behavior and all changes are clearly documented and communicated to direct care staff
4) When new interventions are implemented, there is documentation to support the effectiveness of the intervention

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the plan of care for resident #047 set out clear directions to staff and others who provide direct care to the resident.

Resident #047 was admitted to the home on a specified date.

The "Admission Resident Profile and Assessment" form was completed by RN #112 with assistance from the resident's family members. This assessment included information about resident #047's transfer and mobility status.

A hand written, 8 ½ by 11 sheet of paper with no date and no signature was also noted to be in resident #047's paper chart, which indicated further information about resident's ambulation, fall risk and mood.

During an interview with RN#112, they stated that resident #047 was asleep in their wheelchair with a specified fall prevention intervention in place during the initial admission. They stated the family said this was the resident's normal state. The RN asked the family if the resident could walk and they said the resident could walk, but with assistance. The RN also recalled having a discussion with the family about the resident having two other specified fall prevention interventions in place while in bed. When asked if there was discussion during admission with the family about other specified fall prevention interventions, they stated they recalled this being brought up but did not document that part of their conversation.

In a phone interview with one of resident #047's family members, they stated that during admission they emphasized to staff that the resident requires two specified fall prevention interventions in place.

Upon review of resident #047's paper chart, the inspector noted that there was a consent form paper-clipped to the outside of the chart for the use of two specified fall prevention interventions, dated on admission, that had not yet been signed.

The inspector also noted that a Restraint Initial Assessment had been completed for resident #047 in PointClickCare the date the resident was admitted. This assessment stated reasons for the specified restraint and listed contributing factors. The inspector noted that another specified fall prevention intervention was not checked in this assessment.

The first evening the resident was in the home, RPN #116 charted that the resident was agitated, was self-transferring and walking independently. The resident was also noted to become aggressive with staff when intercepted.

The day following resident #047's admission RPN #117 and RPN #118 charted that

the resident exhibited agitation, wandering and exit seeking behavior and was walking without using their wheelchair. On the same date, the Resident and Family Services Manager (RFSM) #119 also charted requesting assistance from an outside agency to assist in transitioning resident #047 to the home.

On October 22, 2018, the RFSM indicated in an interview that when they spoke to the family of resident #047 they would have stated the outside agency was to help with the transition to the home and to help the resident settle and no other care specific details were discussed related to the resident's care and/or behaviours.

The day following resident #047's admission, RPN #120 charted that resident #047's gait was unsteady arising from a chair and that the resident was assisted into their wheelchair with effect.

Two days following resident #047's admission, the resident was noted by RN #121 to be attempting to self-transfer into chairs.

RPN #117 was interviewed at approximately 1300 hours on October 22, 2018. They stated that resident #047 would often move around, remove one of the specified fall prevention interventions and would walk without assistance and wander. They stated that staff tried to keep an eye on the resident as much as they could. RPN #117 stated that another specified fall prevention intervention was put in place at some point but they could not recall it working. They thought maybe the resident removed the specified intervention. They recalled the resident having another specified fall prevention intervention, which would be in place and then next thing staff knew the resident would be up and walking again. They stated they would redirect the resident to their wheelchair and reapply the specified fall prevention intervention. RPN #117 stated that they communicated pertinent information to the RN on the shift and also give this information at shift report to PSWs and the oncoming RPN. They stated there is also a written shift report, which they believe is kept and filed.

Inspector #197 requested copies of the shift report sheets from the Director of Care for three specified dates for the wing where resident #047 resided. Shift report sheets for two dates were provided and there were no notes on the shift report sheets to indicate the use of any of the noted specified fall prevention interventions, the fact the resident could remove one of the specified fall prevention interventions or any

contact with the resident's family to discuss the resident's care.

On a specified date and time, RPN #122 charted that resident #047 was up early that morning and wandering. They noted that the resident required frequent monitoring and redirection due to wandering. The resident was also noted to be removing one of their specified fall prevention interventions and self-propelling in their wheelchair. On the same specified date, RPN #122 also noted that there was a team member from an outside agency in at the time working one-on-one with resident #047. The RPN also documented a conversation with the resident's family at this time but there was nothing related to the resident's specified fall prevention interventions, consent for a fall prevention intervention to be signed or the resident's recent behaviours. At a later time on the same specified date, RPN #116 documented that resident #047 had an unwitnessed fall in another resident's room and was sent to the hospital for further assessment.

During an interview with RPN #116, they stated that they were working the first evening shift after the resident was admitted on a specified date. RPN #116 said the resident was very agitated and was walking independently without issue. Staff saw this and rushed to assist the resident. They stated that staff was under the impression at first that resident #047 could not remove a specified fall prevention intervention but they witnessed the resident remove the specified intervention very easily. The RPN noted that the resident was agitated with staff, was exit seeking and wandering.

RPN #116 stated that their next shift in the home was when the resident fell. At the beginning of RPN #116's shift, resident #047 had an unwitnessed fall. RPN #116 could not say whether the resident had a specified fall prevention intervention applied just before the fall since this was the first time seeing the resident on the shift. When asked if the resident had a specified fall intervention in place, they stated they were unsure and did not know of the specified intervention being used for resident #047.

PSW #123 who works with an external program, was interviewed and stated that they were in the home with the resident for approximately one hour just prior to the resident #047 falling. They indicated they were in the home at the time of the fall but with another resident. They stated that resident #047 did not have a specified fall prevention intervention in place at the time of their visit, although noted the resident did have one present. They stated they were told by RPN #116 that the resident

could remove the specified fall prevention intervention.

PSW #124 who also works with an external program, was also interviewed since they worked with resident #047 on two specified dates prior to the fall. On both days, they indicated that the resident did not have a specified fall prevention intervention in place since the consent had not been signed. They also could not recall any other specified fall interventions being in place for resident #047. They stated that on one of the specified dates, they did not recall the resident having a specified fall prevention intervention in place while in bed, but the resident did have another in place.

Two PSW's (#126 and 127) that worked the date that resident #047 fell, were interviewed. PSW #126 stated that they worked the first shift the resident was admitted, assisted them to bed and noted that shortly after, the resident was up wandering. They recalled the night staff implementing a specified fall prevention intervention and the next time they saw the resident they had the specified intervention in place.

PSW #127 stated that staff were told the resident could not walk and was a two-person transfer when they were first admitted. They stated that the resident could walk and could also get out of bed even when a specified fall prevention intervention was in place. They said that they would sit the resident down in their wheelchair and had asked the RPN if it was ok to apply a specified fall prevention intervention but was told they could not. The PSW could not recall who told them the intervention could not be used for resident #047. PSW #127 went on to say the next day they worked in the home, the resident did have the specified fall prevention intervention in place, but was told the resident could remove it. They stated when they left the home following their shift on the date prior to the fall, the resident was in their wheelchair but no specified fall prevention intervention was in place.

PSW #100 worked on two specified dates prior to the resident's fall. The PSW said that over the course of the two days they never saw the resident in their wheelchair. They said the resident was up and walking constantly and seemed quite steady on their feet. PSW #100 stated that there was one other specified fall intervention in place and they thought there may have been a second specified fall prevention intervention in place but could not recall for sure since they never saw the resident in their wheelchair.

RPN #129 that worked the day shift on the date resident #047 fell was interviewed and indicated this day was the first time they had met resident #047. They reviewed their progress notes that were made and recalled that there was some discussion about how the resident could remain safe. They also indicated that they were aware that the family wanted everything in place to keep the resident safe and listed three specified fall prevention interventions in place for the resident. RPN #129 indicated they did not recall another specified fall prevention intervention being implemented for resident #047 but did recall that there was some discussion about it.

During interviews with the Director of Care (DOC), they stated that they had not spoken to resident #047's family in the three days after the resident was admitted and prior to the fall to discuss the resident's care. They stated that their expectation of staff in this type of situation would have been to get additional support and do more one-to-one care. They also stated they would have expected staff to discuss the resident's care with the family. The DOC stated that if new interventions were being put into place for a resident, the charge nurse would discuss at report, the RPN would then discuss with the care team and they would also expect that there would be documentation in the progress notes.

According to the admitting RN and the family of resident #047, three specified fall prevention interventions were discussed for the resident. The consents for two of the specified fall prevention interventions dated on the resident's admission were not signed. The Restraint Initial Assessment indicated a specified fall prevention intervention was required, but not another specified intervention and the inspector could not find any documentation in the resident's paper or electronic chart related to the use of a third specified fall prevention intervention. Interviews with multiple staff members including RN's, RPN's and PSW's demonstrated that the three fall prevention interventions discussed at admission were not consistently in place over the time the resident was in the home and some staff were unsure if one of the specified fall prevention intervention could be used. Therefore, the plan of care for resident #047 did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

The decision to issue this non-compliance as a compliance order was based on the following:

The severity of this non-compliance is a level 3 (Actual Harm/Risk) as resident #047 fell and sustained a fractured hip.

The scope of this non-compliance is determined to be a level 1 (isolated) as only one resident in the home was affected.

The home has a level 2 compliance history (1 or more unrelated non-compliances in the last 36 months). (197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee must be compliant with O. Reg 79/10 s. 23.

Specifically, the licensee shall:
a. Ensure that when residents #021, #045 and #049 and any other resident who has a seat belt applied, the device is applied according to manufacturer's instructions.
b. Ensure that all staff members who are responsible for the application and assessment of resident seat belts, receive education to ensure they are aware of how to apply the device, the risks associated with improperly applied seat belts and what action to take when a seat belt is not applied appropriately. This education shall be documented.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that seat belts were applied in accordance with the manufacturer's instructions.

On a specified date, resident #021 was observed sitting a wheelchair with a front closing seat belt applied. It was noted by Inspector #541 that the belt appeared loose and could be pulled 3-4 inches away from the resident.

On a specified date, resident #045 as observed sitting in a wheelchair with a front closing seat belt applied. It was noted by Inspector #541 that the belt appeared loose and could be pulled 5-6 inches away from the resident. The Director of Care (DOC) was present at the time the inspector observed resident #045's seat belt and the DOC confirmed the belt was not applied appropriately.

On another specified date, resident #045 was again observed in a wheelchair with a front closing seat belt applied and it could be pulled 2-3 inches away from the resident.

On another specified date and time, Inspector #197 observed resident #049 in front of the nursing station by the large dining room sitting in a wheelchair with a seat belt done up very loosely with the buckle hanging below the residents knees.

Manufacturer's instructions for the front closing seat belts were provided to Inspector #541 by Physiotherapist #111. The document is titled "Pelvic Support User's Guide" by Bodypoint. The instructions stated that the belt it to be kept tight during fitting and maintain this tightness during daily use to ensure correct placement. For non-paddded hip belts, the adjustment strap at the buckle should be approximately 4-6 inches long. It further stated that "teaching the caregiver techniques is essential for correct hip belt positioning."

Residents #021, #045 and #049 did not have their seat belts applied according to the manufacturer's instructions.

The decision to issue a compliance order was based on the following:
- The severity of the issue was determined to be a level 2 as there is potential for actual harm to residents.
- The scope of the issue was a level 3 as it related to three of the three residents reviewed.
- The compliance history was a level 3, in that the home had one or more related non-compliance in the past 3 years (541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2019

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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

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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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 12nd day of March, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by AMBER LAM (541) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

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