Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 26, 2015	2015_216144_0010	L-001756-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ESSEX
360 Fairview Ave West ESSEX ON N8M 1Y6

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

SUN PARLOR HOME FOR SENIOR CITIZENS
175 TALBOT STREET EAST LEAMINGTON ON N8H 1L9

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

CAROLEE MILLINER (144), ALISON FALKINGHAM (518), PATRICIA VENTURA (517), ROCHELLE SPICER (516)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 3, 4, 5, 6, 9, 10, 11, 12, 2015

During the course of the inspection, the inspector(s) spoke with 40 plus residents, three family members, the Administrator, Director of Nursing & Personal Care, Assistant Director of Nursing & Personal Care, the Administrative Assistant, Accounting Clerk, Ward Clerk, Manager of Health and Safety, Manager of Food and Nutrition, the Registered Dietitian, Manager of Life Enrichment, Physiotherapist, Housekeeping Supervisor, Manager of Building Services, sixteen Registered Nurses, seventeen Registered Practical Nurses, eighteen Personal Service Workers, nineteen Health Care Aides, three Food Service Workers, two Life Enrichment staff, one housekeeping staff and two maintenance personnel.

During the course of the inspection, the Inspector(s) toured all resident home areas, medication rooms, observed dining service, medication administration, provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices, reviewed resident's clinical records, posting of required information, meeting minutes related to the inspections and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the written plan of care for each resident sets out the planned care for the resident as evidenced by:

a) The clinical record for one resident identifies the resident as having a communication problem.
b) The current modified resident assessment protocol (RAP) summary identifies the

resident's communication problem will be care planned.
c) The current written plan of care for the resident does not include communication concerns.
d) One registered staff confirmed the modified RAP for this resident is accurate and that a written plan of care should have been developed to address the resident's communication problem. s.6(1)(a) [s. 6.]

2. The licensee did not ensure that there is a written plan of care for each resident that sets out the planned care fore the resident as evidenced by:

a) The current multiple data collection (MDS) assessment for one resident identifies they are incontinent & experience constipation.
b) The resident RAP confirms the incontinence.
c) Review of the resident's clinical record confirmed the resident has been administered prn laxatives on specific dates.
d) The clinical record further confirmed the resident also receives stool softeners.
e) One registered staff concurred that the resident has a diagnosis of constipation and that a written plan of care has not been developed to address the resident's incontinence and constipation.
f) One nurse manager agreed that it is the expectation of the home that a written plan of care be implemented to address the resident's constipation and bowel incontinence. s.6(1)(a) [s. 6.]

3. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident as evidenced by:

a) Review of the written plan of care for one resident revealed:
The resident will maintain their ability to toilet independently.
The resident requires minimal assistance from two persons for hygiene purposes after toileting.
The resident will put on at least one item of clothing without assistance.
b) The resident's MDS assessment revealed the resident requires extensive assistance of two persons for physical assistance for toileting and dressing.
c) Interview with one Registered Nurse (RN), one Registered Practical Nurse (RPN) and three Personal Support Workers (PSW's)revealed the resident was not on a toileting routine, requires extensive assistance of two staff members for all transfers and could not toilet or dress themself.

d) The Assistant Director of Nursing and Personal Care (ADONPC) verified the expectation was that care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident and in this instance, the resident was not assessed properly. s.6(2) [s. 6.]

4. The licensee did not ensure that there is a written plan of care for each resident that sets out the planned care for the resident as evidence by:

a) One resident is prescribed a specific medication at regular intervals daily and prn.
b) The resident was observed by two Inspector's speaking inappropriately to other resident & staff.
c) The quarterly assessment for the resident includes a modified RAP for the use of the prescribed medication with an inclusion that the medication will be care planned.
d) The current written plan of care does not include the planned care for the resident related to the use of the specific medication.
e) Two registered staff confirmed that the health concerns identified in a resident's RAP should be reflected in the written plan of care. s.6(1)(c) [s. 6.]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary as evidenced by:

a) The Power of Attorney (POA) for one resident revealed concerns regarding the resident's comfort related to seating.
b) Two Inspectors observed the resident's potential discomfort related to seating.
c) Interviews with four nursing staff revealed the resident has seating concerns.
d) Clinical record review for this resident revealed the resident's seating has not been assessed by an Occupational Therapist (OT) for over three years. At that time, seating concerns were not identified.
e) One RN and the DONPC explained the expectation was that when the resident's care needs changed and they developed seating concerns, an OT assessment should have been offered to the resident/SDM and that this did not take place for this resident. s.6(2) [s. 6.]

6. The licensee of a long-term care home did not ensure that there is a written plan of care for each resident that set out, (c) clear directions to staff and others who provide direct care to the resident as evidenced by:

a) One resident was observed throughout the RQI sitting in a wheelchair with a specialty cushion.
b) Interviews with three nursing staff revealed the resident has a history of wounds and requires interventions for pressure relief.
c) One PSW stated a specific function on the wheelchair was being used so the resident did not fall out of the chair.
d) A second PSW stated the function on the wheelchair was being used to assist with repositioning of the resident at regular intervals
e) A third PSW and one RN stated the function on the wheelchair was being used to promote comfort and assist with positioning and repositioning.
f) Review of the clinical record for the resident confirmed observed interventions for pressure relief were not listed in the resident's written plan of care.
g) The ADONPC shared that the resident's written plan of care is not current and clarification was required for staff and others that provide direct care to the resident related to use of the wheelchair functions. s.6(1)(c) [s. 6.]

7. The licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident as evidenced by

a) Observations of one resident in bed and interviews with two registered staff confirmed this resident uses multiple bed rails as a personal assistance services device (PASD) when in bed.
b) A logo card is posted at the resident bedside directing staff to use a specific number of bed rails when the resident is in bed.
c) The current written plan of care indicates this resident uses more bed rails than the logo card identifies.
d) The ADONPC advised it is the expectation that the resident's written plan of care include the appropriate number of bed rails in use as well as use of the bed rails as a PASD.
e) The ADONPC also confirmed the written plan of care for this resident does not provide clear directions to staff and others who provide care to the resident related to the number of bed rails they require and that the plan of care also does not include use of the bed side rails as a PASD. s.6(1)(c) [s. 6.]

8. The licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

a) The current and previous quarterly reviews and current fall assessment for one resident indicates the resident is at high risk for falls.
b) The current written plan of care identifies the resident is at low risk for falls.
c) The ADONPC confirmed the resident has been assessed as low to medium risk for falls in the past and is presently high risk.
d) The ADONPC further confirmed the written plan of care does not reflect the current status of high risk for falls and the plan should have been updated to reflect this change in care needs.s.(10)(b) [s. 6.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, the resident had been assessed and his or her bed system had been evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

a) Observations by one Inspector, plan of care review and two registered staff members confirmed one resident has a specialty mattress on their bed and currently uses multiple bed rails.
b) Review of a second resident's plan of care and a PSW confirmed this resident has a regular mattress on their bed and uses more than one bed rail.
c) Review of a third resident's plan of care and a PSW confirmed this resident has a specialty mattress on their bed and uses multiple bed rails.
e) The Manager of Building Services (MBS) confirmed the home did not have a formal process for evaluating bed systems where bed rails are used. The MBS also reported not all of the bed systems with bed rails currently in use by residents within the home, have been evaluated for entrapment zones and other safety issues.
f) The MBS confirmed the bed systems for two of the above identified residents had not been evaluated for entrapment zones and safety issues to minimize the risk to the residents.
g) The MBS confirmed the bed system for one resident was evaluated but did not pass the evaluation due to one entrapment zone failing the evaluation. The manager confirmed no further evaluations have been completed on this resident's bed system and the resident continues to use this bed with a specialty mattress and bed rails.
h) The ADONPC shared the home did not currently have a formal process for assessing residents when bed rails are used in accordance with evidenced based practices and, if there are none, in accordance with prevailing practices, to minimize the risk to the resident.
i) The ADONPC confirmed the identified three residents have not been assessed in relation to their use of bed rails. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not fully respect and promote the resident's right to have his or her lifestyle and choices respected as evidenced by:

a) Review of one resident's clinical record and interview with the POA for the resident revealed the family provided specific clothing for the resident's comfort and requested the clothing item be put on the resident daily when they are in their wheelchair.
b) The POA further reported they discussed with nursing personnel, their wish for the transfer sling to be removed from the resident's wheelchair when the resident is in the chair and that to date, this has not been done.
c) Interview with one RN and three PSW's revealed staff are aware of the family's choice to put the provided clothing item on the resident after being dressed and that this was not done on the dates identified by the Inspector.
d) The same staff verified the resident right to have their choices respected related to wearing the family provided clothing item.
e+) The ADONPC confirmed the resident's right to have their choices respected related to wearing the provided clothing item and having the sling removed when sitting in the wheelchair. [s. 3. (1) 19.]

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 the licensee fully respects and promotes the resident's right to have his or her lifestyle and choices respected, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with as evidenced by:

a) Review of the home's policy titled "Nutritional Care, Hydration" last revised June 6, 2002, revealed the evaluation of resident fluid intakes are to be completed by the RPN's on Wednesdays and Saturdays during the day shift. Following the evaluation of fluid intakes, a Nutritional Referral Form is to be sent to the Registered Dietitian (RD) for any resident who had 3 consecutive days with 1000 mls or less of fluid intake.
b) Interview with the ADNPC, one RN and two RPN's revealed that in addition to the referral to the RD, the nursing staff should also assess the resident who had 3 consecutive days with 1000 mls or less of fluid intake for signs and symptoms of dehydration and document the findings in the resident clinical record. The registered staff advised that all resident assessment findings were documented in the resident clinical record.
c) Review of the health record for one resident revealed:
- The resident's fluid intake was less than 1000 mls each on three identified consecutive days.
- The resident was often constipated and administered daily laxatives.
d) The resident's latest RAP summary indicated the resident had fluid intake below estimated requirements and that there were no recent electrolytes to assess hydration.
e) The resident's written plan of care indicated laboratory work should be done for the resident every three months and as needed due to the resident's high nutritional risk.
f) Further clinical record review revealed the resident was not assessed for signs and

symptoms of dehydration for a one month identified time period and staff did not initiate a referral to the RD until the tenth consecutive day with less than 1000 mls of fluid intake. The resident has not received diagnostic studies for electrolytes for eight months.
g) The ADONPC confirmed the expectation was that the resident with fluid intake of less than 1000 mls for three consecutive days should be referred to the RD, have a hydration assessment completed and receive care according to his or her plan of care.
h) The ADONPC also verified that the Nutritional Care, Hydration policy should direct the staff to evaluate fluid intakes daily instead of on Wednesdays and Saturdays so that residents with fluid intakes of less than 1000 mls for three consecutive days could be identified on day three and interventions initiated immediately. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with as evidenced by:

a) The home's policy titled "Monthly Weights" last revised September 23, 2014 states: "Review each resident's weight over the last month. If a difference of plus or minus 2.0 kg is noted, resident must be re-weighed within 24 hours."
b) One resident was not re-weighed when there was a change in weight of plus or minus 2.0 kg from the previous month on:
- when there was a change in weight of 7.1 kg.
- when there was a change in weight of 2.3 Kg.
c) Interview with one RPN confirmed changes in weight of plus or minus 2.0 kg from the previous month required a re-weigh and that this wasn't done for the identified weight changes for resident #23.
d) The ADONPC verified that residents with a change in weight of plus or minus 2.0 kg from the previous month should be re-weighed as directed in the monthly weights policy. [s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access were kept closed and locked as evidenced by:

a) January 3, 2015 at 1050 hours, Inspector #517 observed a door to the outside of the home on first floor south corridor was closed and unlocked.
b) While waiting for maintenance personnel to arrive, the Inspector observed two residents walking down the corridor and past the unlocked door.
c) Interviews with one Food Services Worker (FSW), one Ward Clerk and two maintenance staff revealed the door was normally locked and a swipe card was needed to unlock the door. All four staff verified the door should not be unlocked as residents could exit the building.
d) Maintenance staff resolved the concern immediately and ensured the door was locked.
e) One maintenance staff verified the expectations were that all doors to the outside of the home and accessible to residents were to be kept closed and locked at all times. [s. 9. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access were kept closed and locked, to be implemented voluntarily.

WN #6: 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 of a long-term care home did not ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions as evidenced by:

a) On several days throughout the RQI, one Inspector observed one resident sitting in a wheelchair with a sheet placed between them and the therapeutic cushion.
b) Interview with one RN and three PSW's revealed the resident was using a therapeutic wheelchair cushion for pressure relief the absorbent sheet was used for repositioning.
c) The RN also reported that according to manufacturer's instructions, the resident should sit directly on the therapeutic cushion and linens should not be placed between the resident and the cushion as they would decrease the ability of the cushion to provide pressure relief.
d) The ADONPC confirmed the therapeutic wheelchair cushion should be used in accordance with manufacturer's instructions and this was not done for this resident on the dates identified. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions as evidenced by:, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 29. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised. O. Reg. 79/10, s. 29.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, was reviewed and, if required, revised. O. Reg. 79/10, s. 29.

a) The home's PASD program policy under procedure indicates:
Informed consent for the use of a PASD must be obtained and recorded.
b) Two registered staff and review of one resident clinical record confirmed that one resident uses multiple bed rails as a PASD. Consent for the PASD's was obtained in 2010 for use of less bed rails than confirmed.
c) The use of three bed rails was confirmed by the Inspector through observation of the resident in bed.
d) The ADONPC verified the resident now uses an extra bed rail and that informed consent for the use of the extra rail requires consent and the informed consent was not obtained when the resident's care needs changed. [s. 29.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised, a consent or directive with respect to "course of treatment" or "plan of treatment" is relevant, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) One resident was admitted to hospital within the last year.
b) The RD advised Inspector #144, she anticipated the resident would lose weight during their hospitalization and on the date of hospital admission, assessed the resident as being at high nutritional risk.
c) The resident was readmitted six days later however, their weight was not taken for another two weeks at which time they had lost 6.7 kg.
d) One non-registered nursing personnel confirmed resident's should be weighed on readmission from hospital.
e) One nurse manager confirmed it is the home's expectation that resident's will be weighed on readmission from hospital. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) Review of the clinical record for one resident revealed the resident had a recent fall.
b) The resident advised staff they slipped off the bed.
c) The ADONPC confirmed that a post fall assessment using the home's clinically appropriate assessment instrument had not been completed and should have been as soon as possible after the resident had fallen. [s. 49. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment as evidenced by:

a) One resident has a scabbed wound on their hand.
b) Review of the resident's clinical record reveals they have been found on the floor on several occasions in the last three months and that there is no documentation related to the hand wound.
c) The resident shared they injured their hand at the time of a fall.
d) One registered staff shared they did not know the origin of the wound and that a skin assessment of the area had not been completed.
e) Three non-registered staff shared they did not know the origin of the wound.
f) A second registered staff member confirmed the home policy directs staff to complete a skin assessment for each resident experiencing skin breakdown. [s. 50. (2) (b) (i)]

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

a) One resident has an area of altered skin integrity that has been infected periodically since it was diagnosed.
b) One RN, Health Care Aide (HCA) and the Skin and Wound Care Lead RPN, confirmed the POA/resident has decided not to pursue further treatment to the wound for resolution.
c) The Skin and Wound Care Lead confirmed the resident receives wound care to the affected area to prevent infection and maintain the resident's comfort. It was further confirmed by the RPN that weekly skin and wound assessments should be completed for all wounds.
d) A review of assessments documented in resident's clinical record revealed the home's Skin Assessment Tool was initiated on diagnosis and weekly skin and wound assessments completed on eight occasions during the last seven months.
e) The Inspector was unable to find a weekly skin and wound assessment for approximately fifteen weeks during the last seven months.
f) The ADONPC confirmed weekly skin and wound assessments have not been completed for this resident as required and that the assessments should have been completed each week since diagnosis. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure at least once a year, an evaluation is made to determine the effectiveness of the home's Minimizing of Restraints policy to identify changes and improvements were required to minimize restraining and ensure that restraining is done in accordance with the Act as evidenced by:

a) The ADONPC confirmed an evaluation was not completed in 2014 to determine the effectiveness of the home's Minimizing of Restraining Policy and to identify what changes and improvements were required to minimize restraining and to ensure that restraining is done in accordance with the Act and Regulation. [s. 113. (b)]

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 at least once a year, an evaluation is made to determine the effectiveness of the home's Minimizing of Restraints policy to identify changes and improvements to minimize restraining and ensure that restraining is done in accordance with the Act and Regulation, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the training provided for all staff who apply physical devices or who monitor residents restrained by a physical device included potential dangers of these physical devices as evidenced by:

a) Observations of residents by two Inspectors during the RQI revealed the use of possible physical restraints and/or personal assitive devices (PASD's) with the potential of physically restraining residents.
b) The observations included five residents with potential restraints in use.
c) The 2014 staff training records and course content for minimizing of restraining including restraining by a physical device was provided to the Inspector during the RQI.
d) During review of the training course content of the program, it was noted that the content did not include potential dangers of physical devices used for restraint.
e) The Manager of Life Enrichment confirmed the staff training for 2014 did not include information on the potential dangers of physical devices used for restraint. [s. 221. (1) 5.]

2. The licensee failed to ensure the training provided for all staff who apply PASD's or who monitor residents with PASD's included potential dangers of these PASD's as evidenced by:

a) Observations of residents by two Inspectors during the RQI revealed the use of PASD's with the potential of also physically restraining residents. The observations included:
b) The observations included five residents with potential PASD's in use.
c) The 2014 staff training records and course content for use of a PASD was provided to the Inspector during the RQI.
d) The training course content was reviewed by the Inspector. It was noted that the content did not include the potential dangers of PASD use.
e) The Manager of Life Enrichment confirmed the staff training for 2014 did not include information on the potential dangers of PASD's. [s. 221. (1) 6.]

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 the training provided for all staff who apply physical devices includes potential dangers of these devices, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the nutrition care and hydration program apply to a resident's height upon admission and annually thereafter as evidenced by:

a) One registered staff confirmed that the clinical record for one resident does not include a recorded height within the last two years.
b) A second registered staff confirmed another resident's clinical record does not include a recorded height for the last 15 months.
c) The Administrator confirmed it is the expectation and home policy that all resident heights be taken annually and recorded in their clinical record. [s. 68. (2) (e) (ii)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee failed to ensure proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance as evidenced by:

a) Dining service observation was conducted February 03, 2015, during the lunch meal.
b) Near the end of the meal service, one RPN and Inspector #516 observed three PSW's provide and/or attempt to provide fluids to two residents while the staff members were standing and both resident's sitting.
c) Follow up with the Manager of Food and Nutrition Services (MFNS) and the RD in regards to the observation revealed the acceptable practice for assisting residents with oral intake is for staff to be seated at eye level with the resident unless otherwise directed by the resident's plan of care to ensure safety during intake.
d) The clinical records for both residents were reviewed. There is no inclusion in the plan of care for either resident directing staff to stand while providing them with assistance with oral intake.
e) The MFNS and the RD confirmed staff should have been seated and at eye level when providing oral intake assistance to these identified residents. [s. 73. (1) 10.]

Issued on this 27th day of March, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROLEE MILLINER (144), ALISON FALKINGHAM (518), PATRICIA VENTURA (517), ROCHELLE SPICER (516)
Inspection No. / No de l'inspection :	2015_216144_0010
Log No. / Registre no:	L-001756-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 26, 2015
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF ESSEX 360 Fairview Ave West, ESSEX, ON, N8M-1Y6
LTC Home / Foyer de SLD :	SUN PARLOR HOME FOR SENIOR CITIZENS 175 TALBOT STREET EAST, LEAMINGTON, ON, N8H-1L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lynda Monik

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To THE CORPORATION OF THE COUNTY OF ESSEX, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure steps are taken so that the written plan of care for each resident sets out the planned care for the resident.

The written compliance plan shall include at a minimum, the following:

1. A written description of the plan to to ensure the written plan of care for each resident sets out the planned care for the resident.
2. Development of a process to evaluate that the written plan of care for each resident sets out the planned care for the resident.

The plan shall be submitted to Carolee Milliner, LTC Homes Inspector, either by mail or email to: 130 Dufferin Avenue, 4th Floor, London, ON N6A 5R2 or carolee.milliner@ontario.ca by April 17, 2015.

Grounds / Motifs :

1. The licensee did not ensure the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary as evidenced by:

a) Resident #85's October 2014 and January 2015 quarterly reviews and current fall assessment indicate the resident is at high risk for falls.
b) The January 2015 written plan of care identifies the resident as low risk for falls.
c) The Assistant Director of Nursing & Personal Care (ADONPC) confirmed resident #85 has been assessed as low to medium risk for falls in the past and is presently at high risk.
d) The ADONPC further confirmed resident #85's current written plan of care

does not reflect the status of high risk for falls and that the plan should have been revised to reflect this change in care needs. s.6(10)(b) (516)

2. The licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident as evidenced by:

a) Observations of resident #12 in bed and interviews with two registered staff confirmed this resident uses three half bed rails as a PASD when in bed.
b) A logo card is posted at the resident's bedside directing staff to use three half bed rails when the resident is in bed.
c) The current written plan of care indicates this resident uses four half bed rails.

d) The ADONPC advised it is the expectation that the resident's written plan of care includes the appropriate number of bed rails in use as well as use of the bed rails as a PASD.
e) The ADOCPC confirmed resident #12's written plan of care does not provide clear directions to staff and others who provide direct care to the resident related to the number of bed rails she requires and that the plan of care also does not include use of the bed side rails as a PASD. s.6(1)(c)
(516)

3. The licensee did not ensure that there is a written plan of care for each resident that sets out the planned care for the resident as evidence by:

a) Resident #25 is prescribed psychotropic medication three times daily and twice daily prn for responsive behaviours.
b) On February 5, 2015, the resident was observed by Inspector #518 being verbally and physically threatening to other residents using her walker.
c) On February 9 and 11, 2015, the resident was observed by Inspector #144 being verbally abusive toward residents and staff.
d) The November 16, 2014 quarterly assessment for the resident includes a modified resident assessment protocol (RAP) for the use of psychotropic drugs. The RAP identifies the use of psychotropic drugs will be care planned.
e) The February 9, 2015 written plan of care does not include the planned care for the resident related to the use of psychotropic drugs.
f) Two registered staff confirmed the resident exhibits responsive behaviours and that the health concerns identified in a resident's RAP, should be reflected in the written plan of care. s.6(1)(c) (144)

4. The licensee did not ensure that there is a written plan of care for each resident that sets out the planned care fore the resident as evidenced by:

a) The January 11, 2015, multiple data collection (MDS) assessment identifies that resident #17 is incontinent of bowel and experiences constipation.
b) The January 12, 2015, RAP confirms the bowel incontinence.
c) Review of the resident's clinical record from January 3, 2015 to February 9, 2014, confirmed the resident has been administered a liquid laxative on 14 of the last 41 days and a suppository on 2 of the last 41 days.
d) The clinical record further confirmed the resident also receives an oral stool soften twice daily and a second liquid laxative daily since January 15, 2015.
e) One registered staff concurred that the resident has a diagnosis of constipation and that a written plan of care has not been developed to address the resident's bowel incontinence and constipation.
f) One nurse manager agreed that it is the expectation of the home that a written plan of care be implement to address the resident's constipation and bowel incontinence. s.6(1)(a) (144)

5. The licensee did not ensure that the written plan of care for each resident sets out the planned care for the resident as evidenced by:

a) Resident #63's clinical record identifies the resident as having a communication problem in that they may misunderstand the intent of a verbal message in new situations.
b) The December 3, 2014 modified resident assessment protocol (RAP) summary identifies the resident's communication problem will be care planned.
c) The current written plan of care for the resident, does not include communication concerns.
d) One registered staff confirmed the modified RAP for this resident is accurate and that a written plan of care should have been developed to address the resident's communication problem. s.6(1)(a) (144)

6. The licensee of a long-term care home did not ensure that there is a written plan of care for each resident that set out, (c) clear directions to staff and others who provide direct care to the resident as evidenced by:

a) Resident #23 was observed throughout the RQI sitting in a tilted wheelchair on a specialty cushion. Observations of the resident's room revealed the resident uses a low air loss surface on her bed.

b) Interviews with one Registered Nurse (RN), one Registered Practical Nurse (RPN) and three Personal Support Workers (PSW's) revealed the resident had a recently healed pressure ulcer on her buttocks and required interventions for pressure relief to prevent future pressure wounds.
c) One PSW stated the tilt function on the wheelchair was being used so the resident did not fall out of the chair as she leans forward and to the left when sitting in the chair.
d) A second PSW stated the tilt function on the wheelchair was being used to assist with the repositioning of the resident every two hours to relieve pressure.
e) A third PSW and one RN stated the tilt function on the wheelchair was being used to promote comfort and assist with positioning and repositioning.
e) Review of the clinical record for resident #23 confirmed pressure relief interventions such as the specialty wheelchair cushion, an air mattress and tilt wheelchair were not included in the resident's written plan of care.
f) The ADONPC shared that the resident's written plan of care is not current and does not set out clear directions to staff and others who provide care to the resident with respect to pressure relief interventions and use of the tilt wheelchair. s.6(1)(c)
(517)

7. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident as evidenced by:

a) Review of the written plan of care for resident #23 revealed:
The resident will maintain their ability to toilet themselves safely and appropriately through the review date. The resident requires minimal assistance of two persons for safety during transfers. Assistance is required for incontinent product change/ clothing adjustment/ wash hands.
The resident will put on at least one item of clothing without assistance. Resident will dress self appropriately.
The resident has an ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to and evidenced by immobility and cognitive impairment. The goal is to show reduction in size and stage of pressure ulcer.
b) Review of the resident's MDS dated December 28, 2014 revealed:
The resident requires extensive physical assistance of two persons for transfers for toileting and dressing and did not have a pressure ulcer.
c)) Interview with one RN, one RPN and three PSW's revealed resident #23 was

not on a toileting routine, required extensive assistance of two staff members and a maxi lift for all transfers and could not toilet or dress independently and did not have a pressure ulcer.
d) The ADONPC verified the expectation was that care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident and that in this instance, the assessment of the resident was not accurate with respect to the their needs and preferences. s.6(2) (517)

8. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary as evidenced by:

a) When interviewed, the Substitute Decision Maker (SDM) for resident #23 revealed concerns regarding the resident's comfort when sitting in her wheelchair. He stated the resident was leaning to one side and not sitting straight and that a seating assessment by an Occupational Therapist (OT) was not suggested for the resident by the home.
b) On February 6 and 9, 2015, Inspectors #144 and #517 observed resident #23 leaning to the left when sitting in her wheelchair.
c) Interviews with three PSW's revealed the resident has difficulty sitting upright in her wheelchair and always leans to the left. Interview with one RN revealed resident #023 always leans to her left when sitting in her wheelchair and does not look comfortable.
d) Clinical record review for resident #023 revealed the resident's seating was last assessed by an OT on December 20, 2011. During the last seating assessment the resident was found to be positioned appropriately in the wheelchair.
e) One RN and the DONCP explained the expectation was that when the resident's care needs changed and she was no longer seated upright in her wheelchair, an OT seating assessment should have been offered to the resident and SDM and this did not take place for resident #023.
s.6(2) (517)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 17, 2015

Order # / Ordre no : 002

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

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 shall prepare, submit and implement a plan to ensure steps are taken to ensure that where bed rails are used, the resident and his or her bed system is evaluated.

The written compliance plan shall include at a minimum, the following:

1. A written description of of the plan to evaluate bed rails and bed systems.
2. Development of a process to evaluate residents in their beds.
3. Use of evidenced based practices and, if there are none, prevailing practices.
4. Identification of a safety threshold for continued use of bed rails or a bed system
5. Identification of risk factors related to the use of bed rails and bed systems.
6. Directives for follow-up if bed rails or a bed system does not meet the safety criteria for use.

The plan shall be submitted to Carolee Milliner, LTC Homes Inspector, either by mail or email to: 130 Dufferin Avenue, 4th Floor, London, ON N6A 5R2 or carolee.milliner@ontario.ca by April 17, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails are used, the resident had

been assessed and his or her bed system had been evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident as evidenced by:

a) A progress note documented in resident #12's health care record on January 24, 2015, revealed a staff member "responded to resident calling out from his room. The resident had slid to the side of his air mattress and was positioned between the bed rail and the side of the air mattress on the right side. The resident was repositioned by two staff members. Some redness was noted on the resident's right temple. The resident denied pain and his vital signs were within normal limit."
b) A progress note documented in resident #12's health record on January 25, 2015, indicated "no injuries were noted from head being on bed rail. The (air) mattress was checked and 2 cells were replaced which could have been the cause as resident sinking in his bed".
c) Review of resident #81's plan of care and a PSW confirmed this resident has a regular mattress on her bed and uses two half bed rails.
d) Review of resident #84's plan of care and one PSW confirmed this resident has an air mattress on her bed and uses four half bed rails.
e) The Manager of Building Services (MBS) confirmed the home does not have a formal process for evaluating bed systems where bed rails are used. The MBS also reported not all of the bed systems with bed rails currently in use by residents within the home, have been evaluated for entrapment zones and safety issues.
f) The MBS confirmed the bed systems for residents #12 and #81 have not been evaluated for entrapment zones and safety issues to minimize the risk to the residents.
g) The MBS further confirmed the bed system for resident #84's was evaluated November 05, 2012 and did not pass the evaluation due to entrapment zone three failing the assessment. The MBS stated no further evaluations have been completed on resident #84's bed system and the resident continues to use this bed with an air mattress and bed rails.
h) The ADONPC shared the home did not currently have a formal process for assessing residents when bed rails are used in accordance with evidenced based practices and, if there are none, in accordance with prevailing practices, to minimize the risk to the resident.
i) The ADONPC confirmed residents #12, #81 and #84 have not been evaluated in relation to their use of bed rails.
(516)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 17, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 26th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROLEE MILLINER

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