Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 22, 2016	2016_341583_0012	017963-16	Resident Quality Inspection

Licensee/Titulaire de permis

BARTON RETIREMENT INC.
1430 UPPER WELLINGTON STREET HAMILTON ON L9A 5H3

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

THE WELLINGTON NURSING HOME
1430 UPPER WELLINGTON STREET HAMILTON ON L9A 5H3

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

KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129), ROSEANNE WESTERN (508)

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): June 16, 17, 20, 21, 22, 23, 24, 28, 29, 30 and July 6 and 7, 2016.

The following inspections were conducted simultaneously with this Resident Quality Inspection:
-Complaint Inspection log #014399-15 related to food quality and continence care
-Critical Incident Inspection log #010740-16 related to responsive behaviours

During the course of the inspection, the inspector(s) spoke with the Administrator, Food Service Supervisor(FSM), Maintenance Manager, Director of Care(DOC), Assistant Director of Care(ADOC), Resident Support Service Worker (RSSW), Physiotherapist (PT), Registered Dietitian (RD), residents, registered staff and Personal Support Workers (PSW) staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

16 WN(s)
11 VPC(s)
3 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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the resident's plan of care was provided to the resident as specified in the plan.

A) Resident #305 reported to staff on an identified date in 2015, that they had pain in specified areas. The resident indicated to staff that the night before, a PSW transferred the resident to bed by themself and injured the resident when they transferred them to bed.

The resident's plan of care for transferring indicated that the resident required two persons for all transfers for safety. After an internal investigation, it was determined that the staff transferred the resident by themself without the assistance of another staff member as directed in the resident's plan.

It was confirmed by the DOC on July 7, 2016, that the care set out in the resident's plan of care was not provided to the resident as specified in the plan. (508)

B) On an identified date in 2015, staff transferred resident #300 from their wheelchair

into the shower chair using a sit to stand lift designed to assist residents not requiring total assistance.

The resident's plan of care directs staff to transfer the resident using a mechanical lift as the resident required total assistance for all transfers. As a result of staff not following the resident's plan of care, the resident sustained several minor abrasions and lacerations to identified areas which required treatment.

It was confirmed by the DOC during an interview on June 30, 2016, that the care set out in the resident's plan of care was not provided to the resident as specified in the plan. (508) [s. 6. (7)]

2. The licensee failed to ensure that the plan of care was revised when the care set out in the plan was no longer necessary.

On June 17, 2016, the adaptive device section of the master diet list located in the second floor dining room was reviewed. It identified resident #206 required specific adaptive devices to assist with eating and resident #207 required specific adaptive devices to assist with eating.

During a lunch observation of the June 17, 2016, resident #206 and #207 did not receive the adaptive devices identified on the master diet list. In an interview with the FSM on June 17, 2016, it was identified that the list may not have been up to date. In an interview with the RD on July 7, 2016, it was confirmed that per resident #206 and #207's care plans they did not require adaptive devices. It was confirmed the master diet list was not revised when the residents no longer required adaptive devices. [s. 6. (10) (b)]

3. The licensee failed to ensure that when the resident was being reassessed and the plan of care was revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A) Resident #009 was identified as a high risk for falls, due to having had two or more falls within the previous three month period. It had been identified that in October 2015, after the fall investigation that cause of the fall was that the resident fell forward out of their wheelchair and sustained an injury.

On an identified date in December 2015, the resident had an unwitnessed fall. On an identified date in December 2015, the resident attempted to self-transfer and fell out of

their wheelchair. On an identified date in January 2016, the resident was reassessed for their risk for falls and was still identified as a high risk.

On an identified date in January 2016, the resident had another fall where it had been identified during the post fall investigation that the resident fell from their wheelchair. No new interventions were implemented at this time and it was documented in the fall investigation notes that the plan was to continue with current interventions.

On an identified date in February 2016, the resident sustained an injury after an unwitnessed fall from their wheelchair. The resident was transferred to hospital due to their injuries.

On an identified date in June 2016, the resident sustained another injury when they fell out of their wheelchair and was transferred to hospital due to another injury. On an identified date in June 2016, the resident attempted to self-transfer out of bed and was discovered by staff on the floor. The resident sustained injuries and was transferred to hospital where it was determined that the resident required an intervention due to an injury to an identified area.

A review of the resident's plan of care identified that the resident was at risk for injuries due to falls. The goals were to decrease the number of falls and have no injuries from falls; however, although interventions were developed and implemented, the resident continued to fall and different approaches had not been considered when the plan was revised.

It was confirmed during an interview with the Assistant Director of Care (ADOC) on June 28, 2016, that when the resident was being reassessed and the plan of care revised because care set out in the plan had not been effective, different approaches were not considered in the revision of the plan of care. (508)

B) On an identified date in May 2016, it was documented in the nursing quarterly summary that resident #002 had 19 falls in a three month period. It was also identified in this summary that a recently purchased wheelchair had not been effective in decreasing the number of falls the resident was having.

New interventions were implemented; however, the resident continued to fall. Between an identified period between May and June 2016, the resident had a specified number of additional falls. During this time, on an identified date in June 2016, staff discussed the

use of a seat belt for the resident's wheelchair; however, the Substitute Decision Maker did not want to consent to the use of the seat belt.

After an identified date in June 2016, the current interventions continued to be implemented and were ineffective as the resident had a specified number of additional falls. No new approaches or interventions were considered.

It was confirmed by the ADOC and the PT during interviews conducted on June 29 and July 6, 2016, that when the resident was reassessed and the plan of care reviewed and revised, different approaches were not considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 care set out in the plan of care is provided to residents as specified in the plan and residents are reassessed and the plan of care is reviewed and revised at least every six months and any other time when the resident's care needs change, to be implemented voluntarily.

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 were used the bed system was evaluated in accordance with evidenced based practices and, if there are none, in accordance with prevailing practices, to minimize the risk to the resident.

Health Canada approved two documents identified as "Guidance Documents" and directed that the recommendations in these documents were to be used to assist health care facilities in the assessment of the resident and the resident's bed system when bed rails were used. These two documents are identified as:

1. " Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", developed by the Hospital Bed Safety Workgroup and dated April 2003.

2. "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", based on the US FDA Guidance entitled "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment", which was developed by the Hospital Bed Safety Workgroup and add adopted by Health Canada in 2006.

A) On June 20, 2016, Inspector #129 reviewed four bed systems to determine if the mattresses fit the bed frames. It was observed that three of the four specified bed systems reviewed had bed rails in use, the mattresses on those bed frames were not contained within mattress keepers and slid easily from side to side on the bed decks. The movement of the mattresses on the bed decks could potentially create an entrapment hazard by increasing the gaps or spaces between various components of these bed systems. An audit of 49 unoccupied beds on the first floor home area that were equipped with bed rails was initiated on June 22, 2016, and it was identified that 37 of the 49 bed systems audited were not equipped with mattress keepers or the mattress keepers were not used appropriately and the mattresses slid easily from side to side on the bed decks creating a potential entrapment risk for the residents in those beds. The Director of Care (DOC) and the Maintenance Manager (MM) participated in a walk about of the first floor home area following this audit and confirmed the above observation. Actions had not been taken to assess the above noted bed systems for potential entrapment risks.

B) The home provided the most recent bed entrapment audit which was identified as having been completed on July 1, 2015. The Maintenance Manager (MM) confirmed that they had completed the bed safety audit with an equipment vendor and they used a

computerized spread sheet provided by the vendor to record information related to the audit. It was noted that the audit sheet did not indicate which zones of entrapment were tested and all beds were identified as having passed entrapment zone testing. A review of the audit completed on July 1, 2015, indicated that at the time of this audit two of the bed systems reviewed were equipped with air mattresses and it was noted that these bed systems passed entrapment testing. In accordance with the guidance document entitled "Adult Hospital Bed: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" air powered mattresses and similar pressure reduction products are partially excluded from the dimensional limit recommendations due to the highly compressible nature of these mattresses and that additional caution should be taken when using these products to ensure a tight fit on the mattress to the bed system. The DOC and the MM confirmed that no additional measures were put in place to mitigate the risk of entrapment for the residents who occupied these beds at the time of the 2015 entrapment audit.

C) During a review of the bed system audit completed by Inspector #129 on June 22, 2016 and confirmed by DOC and MM on June 23, 2016, it was noted three bed systems had bed components altered since the entrapment testing completed by the home on July 1, 2015. It was noted that identified beds were equipped with air mattresses that were not in place during the July 1, 2015, entrapment zone testing. The above noted guidance document indicated that reassessment of the bed system may be appropriate when components of the bed system change (e.g., new bed rails or mattresses). It was confirmed by the DOC and the MM that when the mattresses were changed on the above noted bed frames the bed system was not reassessed related to entrapment risks and no steps were taken to mitigate the risk of entrapment for the residents who occupied the above noted beds. [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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that the staff used safe transferring and positioning devices or techniques when assisting residents.

A) Resident #300 was assessed as requiring a total lift with the assistance of two staff for all transfers. On an identified date in 2015, staff transferred resident #300 from their wheelchair into the shower chair using a sit to stand lift designed to assist residents not requiring total assistance. As a result, the resident sustained an injury which required treatment.

It was confirmed by the Director of Care during an interview on June 30, 2016, that staff used unsafe transferring techniques when assisting resident #300 in 2015. (508)

B) Resident #305 reported to staff on an identified date in 2015, that they had pain in identified areas. The resident indicated to staff that the night before, a PSW transferred them to bed without another staff present and injured them during the transferring to bed.

Resident #305 required the assistance of two staff for all transfers due to weakness and it was determined that the resident had fallen during the transfer and sustained an injury.

It was confirmed during an interview with the Director of Care on July 7, 2016, that staff did not use safe transferring techniques when assisting resident #305. [s. 36.]

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 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).**

**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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that weekly menus were communicated to residents.

During a lunch dining observation on the second floor on June 16, 2016, it was observed that the weekly menu was not posted in the dining room or the corridor of the second floor for the residents. In an interview with the FSM on June 16, 2016, it was confirmed that the weekly menus were not posted and had not been communicated to the residents. [s. 73. (1) 1.]

2. The licensee failed to ensure that residents were provided with the eating aids and assistive devices, required to eat and drink as comfortably and independently as possible.

A review of the master diet list located in the second floor dining room indicated resident #205 required a specified adaptive device at meals. During an observation of the lunch service on June 17, 2016, resident #205 was not provided with the adaptive device. In an interview with the FSM it was confirmed that the adaptive device was not provided as per the master diet list. In an interview with the RD on July 7, 2016, it was confirmed that resident #205 required the adaptive device per the resident care plan. [s. 73. (1) 9.]

3. The licensee failed to ensure that no residents who required assistance with eating or drinking were served a meal until someone was available to provide the assistance required by the resident.

During an observation of the lunch service on an identified date in June 2016, resident #200, #208 and #209 were served a variety of beverages and soup at 1205 hours and did not receive assistance from staff to eat until 1230 hours. At the time of this observation the residents did not take any food or beverages on their own. A review of resident #200's plan of care identified staff were to provide constant encouragement and remain with the resident throughout meals and assist with feeding when resident #200 stopped or was unable/unwilling to feed themselves. A review of resident #208's plan of care identified they required extensive assistance with meals. A review of resident #209's plan of care identified they required total feeding assistance. In an interview with staff #215 it was confirmed resident #200, #208 and #209 were served part of their lunch meal when there were no staff available to provide the residents with the assistance they required. [s. 73. (2) (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 no residents who require assistance with eating or drinking are served a meal until someone is available to provided the assistance the resident requires, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system prepared all menu items according to the planned menu.

On June 20, 2016, the morning snack service was observed. Three staff provided snack service using three different carts.

Staff #162 was observed mixing one and a half small plastic spoons of powdered thickener in 250 milliliters (ml) of juice and did not refer to a recipe. The juice was provided to resident #200 and the resident was observed to cough when they were fed the juice. Long-Term Care (LTC) Homes Inspector #583 reviewed the binder located on the snack cart and referred to the recipe. It identified that resident #200 who was assessed to require a specified type thick fluids and required two Tablespoons (Tbsp) in 250ml of juice to make the desired consistency. In an interview with staff #162 it was confirmed that resident #200's juice was not made to a thick enough consistency.

Staff #175 was observed mixing two small plastic spoons of powdered thickener in 125ml of juice and did not refer to a recipe. The juice was provided to resident #201. Inspector #583 confirmed with staff #175 that there was no recipe for thickening fluids located on their snack cart. The plan of care indicated resident #201 required a specified type of thick fluids and the recipe directed staff to put one Tbsp plus one teaspoon (tsp) in 125ml of juice to make the required consistency.

Staff #182 was observed mixing two and a half small spoons of powdered thickener in 250ml of coffee and did not refer to a recipe. The coffee was provided to resident #202. Inspector #583 confirmed with staff #182 that there was no recipe for thickening fluids located on their snack cart. The plan of care indicated resident #202 required a specified type thick fluids and the recipe directed staff to staff to use two Tbsp plus half a tsp in 250 ml of coffee to make the required consistency.

In an interview with the FSM on June 20, 2016, it was confirmed that all three snack carts did not have Tbsp and tsp measuring spoons to prepare the thickened fluids and two of the three carts were missing copies of the recipes for thickening fluids. It was confirmed that the home failed to prepare nectar and honey fluids as part of the homes planned menu. [s. 72. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the food production system prepares all menu items according to the planned menu, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident who demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours.

Resident #204's care plan identified they had a responsive behaviour focus that was implemented on an identified date in March 2016, that put the resident and other residents at risk. The progress notes documented on an identified date March 2016, noted that staff became aware of the residents behaviour after an incident occurred. After the incident resident #204 was placed on one to one supervision for the night shift.

A review of the resident #204's care plan focus related to the behaviour did not contain strategies or interventions to prevent resident #204 from demonstrating the responsive behaviour. In an interview with the DOC on July 7, 2016, it was confirmed that strategies were not developed or implemented to respond to resident #204's responsive behaviour.

PLEASE NOTE: This non-compliance was identified during a Critical Incident Inspection, log# 010740-16, conducted concurrently during this Resident Quality Inspection. [s. 53. (4) (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, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behvaiours, to be implemented voluntarily.

WN #7: 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 failed to ensure that the resident who exhibited 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, when clinically indicated.

A) Resident #010 had several pressure ulcers including two stage II on an identified areas.

A review of the resident's clinical record indicated that the assessments that were being conducted on these pressure ulcers had not been done weekly on a consistent basis. The resident's weekly pressure ulcer assessment on an identified areas was not completed for one week in April 2016. Two weekly pressure ulcer assessments were not completed on identified dates in June 2016.

It was confirmed by the DOC on June 23, 2016, that the resident's wounds were not assessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument specifically designed for this purpose.

B) Resident #005 had two pressure ulcers both identified as stage II. One of the resident's identified pressure ulcers were not assessed during a four week period on identified dates between May 2016, and June 2016.

It was confirmed through documentation and during an interview with the DOC on June 23, 2016, that the resident's pressure ulcer was not assessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (2) The licensee shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents. O. Reg. 79/10, s. 20 (2).

Findings/Faits saillants :

1. When central air conditioning was not available in the home, the licensee failed to ensure that the home had at least one separate designated cooling area for every 40 residents.

During stage one of the Resident Quality (RQI) inspection on June 17, 2016, Long Term Care (LTC) Inspectors #508 and #583 observed the temperature in the home to be hot. In a family interview conducted on June 17, 2016, for resident #007 and on June 20, 2016, for resident #009, the families shared the home was uncomfortable because the temperature was too hot for the residents.

On June 20, 2016, at 1030 hours, LTC Inspector #583 observed a hygrometer in the second floor dining room which displayed a temperature of 35 degrees Celsius and a relative humidity of 64%. When these values were taken and plotted against a chart developed by Canadian Meteorologists to determine the Humidex (short for humidity index), the value was 49. The Humidex value is a combination of temperature and humidity to reflect the perceived temperature. Any value over 45 is considered "dangerously uncomfortable" and places individuals at high risk for heat related illness if interventions are not implemented.

Per the "Guidelines for the Prevention and Management of Hot Weather Related Illness in LTC Homes", 2012, the legend defined the degree of comfort of a humidex reading of 43 as "yellow-great discomfort avoid exertion" and a humidex reading of 49 as "orange-dangerous".

In an interview with the Maintenance Manager on July 7, 2016, it was confirmed the home had not taken temperature or relative humidity readings of the designated air-cooled areas. The temperature recorded at the second floor nursing station just outside the designated air-cooled area from June 14 to June 20, 2016, was documented as 31, 31, 28, 30, 32, 32, 32, and 32 degrees Celsius.

In an interview with the Maintenance Manager on July 7, 2016, it was confirmed that the second floor did not have a functioning air-cooled area for periods between the dates of May 27 to June 20, 2016. It was confirmed the homes designated air-cooled area was the second floor dining room. It was confirmed that this was related to multiple maintenance issues with the homes cooling system. It was confirmed that the home was unable to consistently implement alternate methods for cooling the designated air-cooled area during this time period, for residents residing on the second floor. [s. 20. (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 when central air conditioning is not available in the home, the licensee will ensure that the home has at least one separate designated cooling area for every 40 residents, to be implemented voluntarily.

WN #9: 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 where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol or procedure, that the plan, policy, protocol or procedure was complied with. The licensee failed to ensure that staff complied with the home's "Bedrail Policy" identified as # NUR-V-52 with a revised date of January 2016.

This policy directed that "all reasonable steps are to be taken to promote resident safety and independence while respecting the resident's right to make their own decisions about the care". Staff did not comply with this direction when completing the "Bedrails Risk Assessment".

A) Resident #002's plan of care indicated, under a "Mobility" care focus, that the resident required the use of bedrails to assist with positioning in bed and turning from side to side. The most recent "Bedrail Risk Assessment" completed on an identified date April 2016,

indicated that staff responded "yes" to a question that asked if the resident had dementia, confusion unable to comprehend or were distressed; answered "yes" to a question that asked was the resident at risk of climbing over the bed rails and answered "yes" to a question that asked was the resident alone at night. The assessment tool directed that for each question staff responded "yes" to they were to consider entrapment issues and alternatives to the use of bed rails. The Director of Care and the clinical record confirmed that staff did not take all reasonable steps to promote safety when no actions were taken to mitigate the risks identified when staff completed the assessment tool.

B) Resident #001's plan of care indicated, under a "Mobility" care focus, that the resident required the assistance of one staff to move in bed and one bed rail against the wall was to be used. The most recent "Bedrail Risk Assessment" completed on an identified date in June 2016, indicated staff responded "yes" to a question that asked if the resident was at risk of climbing over the bed rails. The assessment tool directed that for each question staff responded "yes" to they were to consider entrapment issues and alternatives to the use of bed rails. The Director of Care and the clinical record confirmed that staff did not take all reasonable steps to promote safety when no actions were taken to mitigate the risk identified when staff completed the assessment tool.

C) Resident #009's plan of care indicated, under a "Mobility care focus, that the resident required extensive assistance of one staff with bed rails to move in bed throughout the night and that staff were to encourage the resident to assist with bed rails on each side to move up in bed. The most "Bedrail Risk Assessment" completed on an identified date in April 2015, indicated that staff responded "yes" to a question that asked did the resident have dementia, confusion, agitation, unable to comprehend or are they distressed; answered "yes" to a question that asked was the resident at risk of climbing over the bed rails; answered "yes" to a question asking did the resident's physical or clinical condition increase the risk of entrapment and answered "yes" to a question that asked was the resident alone at night. The assessment tool directed that for each question staff responded "yes" to they were to consider entrapment issues and alternatives to the use of bed rails. The Director of Care and the clinical record confirmed that staff did not take all reasonable steps to promote safety when no actions were taken to mitigate the risk identified when staff completed the assessment tool. [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 where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol or procedure, that the plan, policy, protocol or procedure is complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

A) Resident #304 was walking by resident #303 while in the dining room at lunch time. Resident #303 was physically aggressive to resident #304 when they walked by resident #304's table and injured resident #304. The incident was unprovoked; however, resident #303 did have a history of physical aggression. Resident #304 sustained an injury as a result of this incident.

It was confirmed by the DOC during an interview on July 7, 2016, that resident #304 was not protected from abuse by resident #303.

B) On an identified date in 2016, resident #302 was observed by staff crying in the hallway and told staff that resident #301 "beat them up". The resident was assessed and it was observed that the resident sustained injuries.

Resident #301 was attempting to lay down in resident #302's bed when the altercation occurred.

It was confirmed by the DOC during an interview on July 7, 2016, that resident #302 was not protected from abuse by resident #301. [s. 19. (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 the residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

It was identified on June 16, 2016, during the initial tour of the home that in the resident's tub and shower room resident's personal items were stored in a basket in the cupboard.

These personal items which included used combs, a used nail brush and opened toothbrushes were not labelled and stored all together in this basket. The PSW who was present in the tub/shower room indicated that the resident's personal items should not be stored together and should be labelled to prevent possible cross contamination.

It was confirmed by staff during an interview on June 16, 2016, that staff did not participate in the implementation of the infection prevention and control program. (508) [s. 229. (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 the staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: 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 failed to ensure that their nutrition and hydration program had a system in place to monitor and evaluate the food and fluid intakes of residents with identified risks related to nutrition and hydration.

Resident #203 was observed in bed wearing night clothes on an identified date in June 2016, at two specified times. In an interview with resident #203 at the second specified time they shared they had not eaten and would like something to eat.

In an interview with food handler #108 it was identified that a lunch meal had not been prepared or set aside for resident #203. In an interview with front line staff and per progress notes documented on an identified date in June 2016, resident #203 declined to come to the dining room for both breakfast and lunch.

The food and fluid intake records were reviewed over a 14 day period in June 2016. Resident #203 required a minimum of 1800 milliliters (ml) of fluid per day per the RD's assessment. The fluid intake record indicated resident #203 did not meet their minimum fluid requirement for 10 out of the 13 days reviewed and averaged a fluid intake of 66 percent of their requirements. The meal intake record indicated resident #203 refused 13 meals over the 13 days reviewed. Over a three day period in June 2016, resident #203 did not eat seven out of nine meals.

A review of the plan of care identified that resident #203's nutrition and hydration was last assessed by the RD on a specified date in April 2016, for the nutrition quarterly assessment. At this time it was documented that resident #203 was eating 75-100 percent at most meals and had consumed 77 percent of their fluid requirements.

In an interview with the RD on July 7, 2016, it was confirmed that resident #203 had a significant change in intake since their last assessment and that the resident required reassessment. In an interview with the FSM on July 6, 2016 and the RD on July 7, 2016, it was confirmed that the home did not have a process in place to monitor and evaluate the food and fluid intakes of residents between quarterly nutrition assessments. A referral was not sent to the RD as it was identified that a process was not in place as to who monitored intakes between quarterly assessment or what parameters would indicate a referral was required. [s. 68. (2) (d)]

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 nutrition and hydration program has a system in place to monitor and evaluate the food and fluid intakes of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimized the risk of altercations and potentially harmful interactions between and among residents.

A) Resident #303 had known responsive behaviours which included verbal and physical aggression towards staff and co-residents. On an identified date in December 2015, resident #303 demonstrated a behaviour towards resident #304 causing an injury. The incident was unprovoked. A review of the Critical Incident (CI) report #2784-000036-15, indicated that the resident did have an incident prior to this incident where resident #303

became aggressive with a co-resident when the resident approached them.

A review of the resident's responsive behaviour plan of care, indicated that the resident had responsive behaviours which included interventions to manage the resident's physical and verbal aggression towards staff. The plan did not identify any responsive behaviours towards co-residents, nor did the plan include procedures or interventions to minimize the risk of harmful interactions among co-residents.

It was confirmed by the DOC on July 7, 2016, that procedures and interventions were not developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of the resident's behaviours, including responsive behaviours that minimize the risk of altercations and potentially harmful interactions between and among residents. (508)

B) The licensee failed to ensure that, procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm as a result of a residents responsive behaviours.

In a CI report submitted by the home it was identified that resident #204 demonstrated two responsive behaviours that put the resident and other residents at risk approximately 30 minutes apart on an identified date in April 2016. A review of resident #204's plan of care identified the home was aware that this resident had this responsive behaviour per documentation completed on an identified date in March 2016.

On an identified date in April 2016, staff were alerted to a responsive behaviour demonstrate by resident #204 which put staff and residents at risk. Approximately 30 minutes later on the same identified date in April 2016, staff were alerted to a second incident resulting from resident #204's responsive behaviour. In an interview with the DOC on July 7, 2016, it was confirmed that resident #204 was left unsupervised after the first incident and the source of what caused the first incident had not been determined.

In an interview with the DOC on July 7, 2016, it was confirmed that interventions were not immediately developed and implemented after resident #204 demonstrated the first responsive behaviours. It was confirmed that interventions were not in place at the time of the second incident and the residents and staff were put at risk of harm related to resident #204's responsive behaviours. (583)

PLEASE NOTE: This non-compliance was identified during a Critical Incident Inspection,

log# 010740-16, conducted concurrently during this Resident Quality Inspection. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that concerns or recommendations made by Residents' Council, about the operation of the home, where not responded to in writing within 10 days of receiving the concern or recommendation.

The President of the Residents' Council confirmed that there were usually food and or meal service concerns raised by residents at the meetings. A review of the Resident Council meeting minutes from January 2016, to June 2016, indicated that there was no documentation of those concerns and residents were directed in the minutes to see the "Food Information Board" for documentation of food and meal service concerns. The FSM confirmed that minutes of the food and meal service concerns raised by the residents at the Resident Council meetings were not documented. The FSM provided two "Nursing Home Resident Council Department Manager(s) & Administrator's Reply" forms, used by the home to respond to the Council. A reply form dated June 15, 2016, was documented 42 days following the May 5, 2016, Residents' Council meeting. The reply had not been reviewed by the Administrator and there was no evidence that this reply form was provided to the Residents' Council. [s. 57. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items were offered and available at each meal.

During a dining observation of the lunch service on second floor on June 16, 2016, residents who chose the entree that included a garlic stick all received a half stick. In an interview with the FSM on June 16, 2016, it was confirmed that the planned menu portion was a full garlic stick and that residents received a half portion.

During a dining observation of the lunch service on second floor on June 16, 2016, the first three residents who chose the vegetarian chili with cheese topping entree did not receive cheese on their chili. In an interview with the food service worker that served the residents it was confirmed the residents did not receive cheese on their chili because it had not been sent from the kitchen and was not available in the second floor servery. During a dining observation of the first lunch service on July 7, 2016, all residents who chose the vegetarian chili with cheese topping entree did not receive cheese on their chili. [s. 71. (4)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During this inspection, it was identified that the home's discontinued narcotic storage bin was located in a locked medication room with only one single lock on the bin. The ADOC indicated that this was the only lock on the bin and that these medications were only secured in a single-locked stationary cupboard.

It was confirmed during an interview with the ADOC on June 30, 2016, that the controlled substances were not stored in a separate, double-locked stationary cupboard in the locked area. [s. 136. (2) 2.]

Issued on this 8th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2016_341583_0012
Log No. / Registre no:	017963-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 22, 2016
Licensee / Titulaire de permis :	BARTON RETIREMENT INC. 1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3
LTC Home / Foyer de SLD :	THE WELLINGTON NURSING HOME 1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LISA BRENTNALL

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The Order is made based upon the application of the factors of severity (3 - actual harm/risk), scope (2 - pattern) and compliance history (3 - one or more related non compliance).

The licensee shall ensure that the following is completed.

1. Reassess resident #002 and resident #009 and consider different approaches that will be more effective in reducing the risk of falls.

2. Review the falls prevention and management program to ensure it provides strategies to reduce or mitigate falls per the legislation.

Grounds / Motifs :

1. 3. The licensee failed to ensure that when the resident was being reassessed and the plan of care was revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A) Resident #009 was identified as a high risk for falls, due to having had two or more falls within the previous three month period. It had been identified that in October 2015, after the fall investigation that cause of the fall was that the resident fell forward out of their wheelchair and sustained an injury.

On an identified date in December 2015, the resident had an unwitnessed fall. On an identified date in December 2015, the resident attempted to self-transfer and fell out of their wheelchair. On an identified date in January 2016, the resident was reassessed for their risk for falls and was still identified as a high risk.

On an identified date in January 2016, the resident had another fall where it had been identified during the post fall investigation that the resident fell from their wheelchair. No new interventions were implemented at this time and it was documented in the fall investigation notes that the plan was to continue with current interventions.

On an identified date in February 2016, the resident sustained an injury after an unwitnessed fall from their wheelchair. The resident was transferred to hospital due to their injuries.

On an identified date in June 2016, the resident sustained another injury when they fell out of their wheelchair and was transferred to hospital due to another injury. On an identified date in June 2016, the resident attempted to self-transfer out of bed and was discovered by staff on the floor. The resident sustained injuries and was transferred to hospital where it was determined that the resident required surgery due to an injury to an identified area.

A review of the resident's plan of care identified that the resident was at risk for injuries due to falls. The goals were to decrease the number of falls and have no injuries from falls; however, although interventions were developed and implemented, the resident continued to fall and different approaches had not been considered when the plan was revised.

It was confirmed during an interview with the Assistant Director of Care (ADOC) on June 28, 2016, that when the resident was being reassessed and the plan of care revised because care set out in the plan had not been effective, different approaches were not considered in the revision of the plan of care. (508)

B) On an identified date in May 2016, it was documented in the nursing quarterly summary that resident #002 had 19 falls in a three month period. It was also identified in this summary that a recently purchased wheelchair had not been effective in decreasing the number of falls the resident was having.

New interventions were implemented; however, the resident continued to fall. Between an identified period between May and June 2016, the resident had an additional amount of specified falls. During this time, on an identified date in June 2016, staff discussed the use of a seat belt for the resident's wheelchair; however, the Substitute Decision Maker did not want to consent to the use of the seat belt.

After an identified date in June 2016, the current interventions continued to be implemented and were ineffective as the resident had a specified number of addditional falls. No new approaches or interventions were considered.

It was confirmed by the ADOC and the PT during interviews conducted on June 29 and July 6, 2016, that when the resident was reassessed and the plan of care reviewed and revised, different approaches were not considered in the revision of the plan of care. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

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 Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect to the potential for actual harm to a large number of residents when it was noted that 37 of 49 bed systems reviewed posed potential entrapment risks to residents. Compliance history indicated that r. 15(1)(a)(b) had been previously issued as non-compliant on October 1, 2014, as a Voluntary Plan of Corrective Action and on May 4, 2015, as a Compliance Order.

The licensee shall prepare, submit and implement a plan to ensure that when bed rails are used the resident's bed system is evaluated to minimize risk to the resident and where risk has been identified, steps are taken to prevent resident entrapment. The plan is to include but is not limited to the following:

1. The initiation and documentation of a bed system audit indicating which beds have mattresses that easily slide from side to side on the bed deck while the bed rails are down or in the transfer position. Based on the completed audit, mattresses that easily slide side to side are to be secure.

2. The development and implementation of an interdisciplinary bed safety training program for staff who are responsible for bed system evaluations as well as for all staff providing direct care to residents. This training, at a minimum, is to include information of bed system components in use, the identification of situations that create potential entrapment risks to residents, the types of equipment available in the home that can be used to mitigate the risk of bed entrapment as well as a mechanism and process for interdepartmental communication when bed components have changed, are not functioning properly or any other bed safety concerns identified by staff.

3. The development and implementation of a system for ongoing monitoring of staff's performance in the management of bed system safety concerns.

The plan is to be submitted on or before September 30, 2016, to LTC Homes Inspector Phyllis Hiltz-Bontje at Phyllis.HiltzBontje@ontario.ca.

Grounds / Motifs :

1. 1. The licensee failed to ensure that where bed rails were used the bed system was evaluated in accordance with evidenced based practices and, if there are none, in accordance with prevailing practices, to minimize the risk to

the resident.

Health Canada approved two documents identified as "Guidance Documents" and directed that the recommendations in these documents were to be used to assist health care facilities in the assessment of the resident and the resident's bed system when bed rails were used. These two documents are identified as:

1. " Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", developed by the Hospital Bed Safety Workgroup and dated April 2003.

2. "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", based on the US FDA Guidance entitled "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment", which was developed by the Hospital Bed Safety Workgroup and add adopted by Health Canada in 2006.

A) On June 20, 2016, Inspector #129 reviewed four bed systems to determine if the mattresses fit the bed frames. It was observed that three of the four specified bed systems reviewed had bed rails in use, the mattresses on those bed frames were not contained within mattress keepers and slid easily from side to side on the bed decks. The movement of the mattresses on the bed decks could potentially create an entrapment hazard by increasing the gaps or spaces between various components of these bed systems. An audit of 49 unoccupied beds on the first floor home area that were equipped with bed rails was initiated on June 22, 2016, and it was identified that 37 of the 49 beds systems audited were not equipped with mattress keepers or the mattress keepers were not used appropriately and the mattresses slid easily from side to side on the bed decks creating a potential entrapment risk for the residents in those bed. The Director of Care (DOC) and the Maintenance Manager (MM) participated in a walk about of the first floor home area following this audit and confirmed the above observation. Actions had not been taken to assess the above noted bed systems for potential entrapment risks.

B) The home provided the most recent bed entrapment audit which was identified as having been completed on July 1, 2015. The Maintenance Manager (MM) confirmed that they had completed the bed safety audit with an equipment vendor and they used a computerized spread sheet provided by the vendor to record information related to the audit. It was noted that the audit sheet did not

indicate which zones of entrapment were tested and all beds were identified as having passed entrapment zone testing. A review of the audit completed on July 1, 2015, indicated that at the time of this audit two of the bed systems reviewed were equipped with air mattresses and it was noted that these bed systems passed entrapment testing. In accordance with the guidance document entitled "Adult Hospital Bed: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" air powered mattresses and similar pressure reduction products are partially excluded from the dimensional limit recommendations due to the highly compressible nature of these mattresses and that additional caution should be taken when using these products to ensure a tight fit on the mattress to the bed system. The DOC and the MM confirmed that no additional measures were put in place to mitigate the risk of entrapment for the residents who occupied these beds at the time of the 2015 entrapment audit.

C) During a review of the bed system audit completed by Inspector #129 on June 22, 2016 and confirmed by DOC and MM on June 23, 2016, it was noted three bed systems had bed components altered since the entrapment testing completed by the home on July 1, 2015. It was noted that identified beds were equipped with air mattresses that were not in place during the July 1, 2015, entrapment zone testing. The above noted guidance document indicated that reassessment of the bed system may be appropriate when components of the bed system change (e.g., new bed rails or mattresses). It was confirmed by the DOC and the MM that when the mattresses were changed on the above noted bed frames the bed system was not reassessed related to entrapment risks and no steps were taken to mitigate the risk of entrapment for the residents who occupied the above noted beds. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The Order is made based upon the application of the factors of severity (3 - actual harm/risk), scope (2 - pattern) and compliance history (4 -ongoing non compliance with an order), and the Licensee's history of non compliance with a VPC on January 9, 2014.

The licensee shall ensure that the following is completed:

1. Ensure all residents who require assistance with transfers, including residents #300 and #305 are transferred as directed in their plan of care using safe transferring and positioning devices and techniques.

2. Ensure all direct care staff are educated on how to use transferring devices and how to preform safe transferring and positioning techniques.

3. Ensure there is an auditing process to monitor ongoing compliance related to i) staff using the correct transferring devices ii) staff using the correct transferring techniques, specifically ensuring all residents who require assistance from two staff are transferred by two staff members.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the staff used safe transferring and positioning devices or techniques when assisting residents.

A) Resident #300 was assessed as requiring a total lift with the assistance of two staff for all transfers. On an identified date in 2015, staff transferred resident #300 from their wheelchair into the shower chair using a sit to stand lift designed to assist residents not requiring total assistance. As a result, the resident sustained an injury which required treatment.

It was confirmed by the Director of Care during an interview on June 30, 2016, that staff used unsafe transferring techniques when assisting resident #300 in 2015. (508)

B) Resident #305 reported to staff on an identified date in 2015, that they had pain in identified areas. The resident indicated to staff that the night before, a PSW transferred them to bed without another staff present and injured them during the transferring to bed.

Resident #305 required the assistance of two staff for all transfers due to weakness and it was determined that the resident had fallen during the transfer and sustained an injury.

It was confirmed during an interview with the Director of Care on July 7, 2016, that staff did not use safe transferring techniques when assisting resident #305. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
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 22nd day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Hayes

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