Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 23, 2018	2018_638609_0003	024613-17, 024616-17, 024617-17, 024622-17, 024623-17	Follow up

Licensee/Titulaire de permis

Wikwemikong Nursing Home Limited
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

Wikwemikong Nursing Home
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

CHAD CAMPS (609), SHELLEY MURPHY (684)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 5-9, 2018.

The following intakes were inspected in this Follow-Up inspection;

Compliance Order (CO) #001 from inspection #2017-615638-0017, related to r. 15 (1) of the O. Reg. 79/10, specific to bed rails in the home and the system evaluation;

CO #002 from inspection #2017-615638-0017, related to r. 30 (1) of the Ontario Regulation (O. Reg.) 79/10, specific to general requirements of the home's required programs;

CO #003 from inspection #2017-615638-0017, related to r. 99 of the O.Reg. 79/10, specific to the evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents;

CO #004 from inspection #2017-615638-0017, related to s. 19 (1) of the LTCHA, 2017, specific to the home's duty to protect the residents from abuse and neglect; and

CO #005 from inspection #2017-615638-0017, related to s. 24 (1) of the LTCHA, 2007, specific to reporting certain matters to the Director.

A Critical Incident System (CIS) inspection #2018-638609-0004 was conducted concurrently with this follow-up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Maintenance Manager, Dietitian, Resident Assessment Instrument (RAI) Coordinator, Maintenance staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant internal investigation notes, licensee policies, procedures, programs and resident health care records.

The following Inspection Protocols were used during this inspection:

Reporting and Complaints
Safe and Secure Home

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

4 WN(s)
0 VPC(s)
4 CO(s)
4 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #001	2017_572627_0015	609
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #004	2017_615638_0017	609

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: Misuse or misappropriation of a resident's money.

During inspection #2017-615638-0017, CO #005 was served to licensee on October 24, 2017, related to an incident of potential resident abuse witnessed by the Administrator which was not reported to the Director. The CO had a compliance due date of December 1, 2017. The licensee was ordered to:

“ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.”

A CI report was submitted by the home to the Director which outlined how on the same day resident #003 went missing for greater than three hours, returning to the home with a change in health status.

Inspector #609 reviewed resident #003's progress notes and found that RN #109 documented that the resident had left the home with potential abusers.

During an interview with RN #109 they outlined how the Administrator had given them specific interventions to follow related to possible abuse of resident #003.

During an interview with resident #003, they would not provide any details but verified that they had previous concerns related to potential abuse.

A review of the home's policy titled "Resident Safety" last revised October 2017 indicated that any person who had reasonable grounds to suspect that misuse or misappropriation of a resident's money was to report the suspicion and information upon which it was based to their Supervision, DOC or Administrator. The policy failed to mention that the person reporting the suspicion or that the leadership informed of the suspicion were to make a report to the Director.

During an interview with the Administrator they at first denied any awareness of potential abuse of resident #003, only to change their response later in the interview to that they were aware of potential abuse toward resident #003. The Administrator verified that they did not report the suspicion nor the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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 has failed to ensure that where bed rails were used, (a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps were 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 were addressed, including height and latch reliability.

During inspection #2017-615638-0017, CO #001 was served to the licensee on October 24, 2017, related to bed rail and bed system evaluations. The CO had a compliance due date of December 1, 2017. The licensee was ordered to:

"a) Ensure that where bed rails are used, the resident is assessed and their bed system is evaluated.
b) Obtain and utilize a bed entrapment tool to evaluate every bed systems where bed rails are used.
c) Develop and implement a process to ensure that a full bed rail entrapment assessment is completed for every bed system with bed rails in accordance with the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards"
d) Maintain a record for each bed system evaluated, which includes; the zones of entrapment tested, what the results were, which bed systems failed the entrapment test and what actions or interventions put in place to immediately eliminate the risk to the resident."

While the licensee complied with sections "b" and "d" non-compliance continued to be identified with section "a" and "c" where the licensee was ordered to evaluate bed systems where rails were used as well as develop a process to ensure bed rail assessments were completed using the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" clinical document as a guide.

a) Inspector #684 observed the two recent residents admitted to the home and found resident #004 and #005 had bed rails engaged.

During interviews with resident #004 and #005 they both verified that bed rails had been used on their beds since being admitted to the home.

During an interview with resident #004's Substitute Decision Maker (SDM) they verified that the bed rail had been in place and engaged for months while resident #005's emergency contact believed that the bed rails were engaged since the resident's admission.

A review of the home's policy titled "Resident Services Manual- subsection 4.1.3 C Bed Rails" last revised November 2017 required residents be assessed prior to the use of bed rails.

A review of the health care records of resident #004 and #005 found that the "Restraint: Side Rail Utilization Assessment Form" for both residents was completed two months after resident #004 was admitted and one month after resident #005 was admitted.

A review of the plans of care for resident #004 and #005 found neither care plan had been updated to indicate the residents used bed rails.

During an interview with the DOC, they verified that residents should have been assessed prior to the use of bed rails and that the use of bed rails should have been documented in the residents' plans of care.

b) Inspector #684 observed the two recent residents admitted to the home and found resident #004 and #005 had bed rails engaged.

During interviews with resident #004 and #005 they both verified that bed rails had been used on their beds since being admitted to the home.

During an interview with Maintenance staff member #013, they verified that they were trained in the use of the bed entrapment tool and that the assessment would be documented on the "Bed System Measurement Device Test Results Worksheet". They further verified that neither resident #005 nor resident #004's were evaluated as the registered staff had not made them aware that the residents were using bed rails.

Inspector #684 reviewed the home's policy titled "Resident Rights and Safety- subsection 4.1.3b Bed Entrapment Prevention Program" last revised October 2017 which indicated that residents were assessed for risk associated with bed rail use on admission.

During an interview with the Administrator, they verified that prior to any resident using bed rails there should have been a "Restraints: Side Rail Utilization Assessment" conducted by the registered staff and a "Bed System Measurement Device Test Results Worksheet" completed.

c) During an interview with the Maintenance Manager #101, they indicated that they did not know when bed rails were to be assessed or reassessed and stated that the home required a tracking process to keep up with the assessments that needed to be completed.

During interviews with the Maintenance Manager and Maintenance staff member #108 (responsible for the bed system evaluation), both indicated that they were unaware of the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" or "Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities and Health Care Facilities" guidance documents. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident’s condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the following was complied with in respect to the organized Nutrition and Hydration Program: There must be a written description of the program that included its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and a written record kept relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During inspection 2017-615638-0017 CO #002 was served to the licensee on October 24, 2017, related to the organized programs required under section 8 to 16 of the Act and section 48 of the Regulation. The CO had a compliance date of December 1, 2017, and

ordered the home to:

"ensure the following programs be evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: a) Falls Prevention Program, ensuring that the program is consistent with O.Reg 79/10, s.49., b) Skin and Wound Care Program, ensuring that the program is consistent with O. Reg. 79/10, s.50., c) Continence Care and Bowel Management Program, ensuring that the program is consistent with O.Reg.79/10, s.51., and d) Nutrition and Hydration Program, ensuring that the program is consistent with O. Reg 79/10, s.68., and 69."

While the licensee complied with sections “a”, “b”, and “c” non-compliance continued to be identified with section “d” where the licensee was to evaluate and update their Nutrition and Hydration Program in accordance with evidence-based practices.

During interviews with the Dietary Manager and the Administrator, Inspector #684 requested the Nutrition and Hydration Program policy and procedure and was provided a policy for Feeding and Hydration specifically Feeding and Hydration Protocols as well as the Nutritional Services Manual which was last reviewed November, 2013. They failed to produce any documentation supporting a Nutrition and Hydration Program.

During an interview with the Dietitian they denied being involved in any evaluation of the Nutrition and Hydration Program.

During an interview with the DOC they verified that the Nutrition and Hydration Program had not been evaluated despite the passing of two months since the compliance due date. [s. 30. (1) 1.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”. DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee’s policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (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 and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

During inspection #2017-615638-0017, CO #003 was served to the licensee on October 24, 2017, related to the evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents.The CO had a compliance due date of December 1, 2017. The licensee was ordered to:

“a) Ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it.
b) Ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

c) Ensure that the results of the analysis undertaken under clause (a) are considered in the evaluation.
d) Ensure that the changes and improvements under clause (b) are promptly implemented.
e) Ensure that a written record of everything provided for in clauses (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 and improvements were implemented is promptly prepared.”

While the licensee complied with sections "a", "b", and "e", non-compliance continued to be identified with section "c" and "d", where the licensee was ordered to ensure that the analysis of every incident of abuse or neglect of a resident was considered in the evaluation as well as ensure that the changes and improvements identified in the evaluation were implemented promptly.

a) On a particular day, Inspector #609 requested the home’s 2017 evaluation of the zero tolerance of abuse and neglect of residents policy and was provided with the “Preventing Abuse and Neglect Program: Annual Assessment Tool” dated October 20, 2017.

A review of the annual assessment tool found no mention nor consideration of any analysis of any incident of abuse or neglect of a resident that the home was aware of in the evaluation of the policy.

The 2017 evaluation of the zero tolerance of abuse and neglect of residents policy indicated that incidents were not tracked and therefore their analyses were not considered in the evaluation.

A review of the home’s policy titled “Resident Safety” last revised October 2017 required the results of the analysis of each incident of abuse or neglect of a resident be considered during the annual evaluation.

A review of the home’s Plan of Corrective Action provided by the Administrator indicated that a review of all incidents of abuse and neglect were to be considered in the annual evaluation and that this had a target date of October 20, 2017.

During an interview with the Administrator the requirements under CO #003 were reviewed. The Administrator indicated that only in the 2018 annual evaluation of the zero tolerance of abuse and neglect of residents policy would the analyses of the 2017 incidents be considered and that this would occur sometime in October 2018.

b) A Further review of “Preventing Abuse and Neglect Program: Annual Assessment Tool” dated October 20, 2017, found that the home had identified that tracking of incidents of abuse or neglect of residents were to be implemented.

A review of the home’s policy titled “Resident Safety” last revised October 2017 required that changes and improvements to the policy and practice were promptly implemented.

During an interview with the Administrator they outlined the improvement identified in the 2017 annual evaluation was for the home to begin tracking incidents of abuse and neglect of residents for consideration during the next annual evaluation.

The Administrator indicated that the tracking of abuse and neglect incidents would start in October 2018 or one year after the improvement was identified. [s. 99.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”. DR # 004 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 23rd day of February, 2018

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

Original report signed by the inspector.

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) :	CHAD CAMPS (609), SHELLEY MURPHY (684)
Inspection No. / No de l'inspection :	2018_638609_0003
Log No. / No de registre :	024613-17, 024616-17, 024617-17, 024622-17, 024623-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 23, 2018
Licensee / Titulaire de permis :	Wikwemikong Nursing Home Limited 2281 Wikwemikong Way, P.O. Box114, Wikwemikong, ON, P0P-2J0
LTC Home / Foyer de SLD :	Wikwemikong Nursing Home 2281 Wikwemikong Way, P.O. Box114, Wikwemikong, ON, P0P-2J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cheryl Osawabine-Peltier

To Wikwemikong Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_615638_0017, CO #005;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the LTCHA. Specifically, the licensee shall:

a) Ensure that any person who has reasonable grounds to suspect that abuse or neglect of a resident by the licensee or staff immediately reports the suspicion and the information upon which it is based to the Director.

b) Ensure that the Administrator and DOC are retrained in the home's zero tolerance of abuse and neglect of residents policy and procedure. The home will maintain a record of the required retraining.

c) Specifically guarantee that any reasonable suspicion of abuse or neglect of a resident that the Administrator or DOC becomes aware of is immediately reported to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately

reported the suspicion and the information upon which it was based to the Director: Misuse or misappropriation of a resident's money.

During inspection #2017-615638-0017, CO #005 was served to licensee on October 24, 2017, related to an incident of potential resident abuse witnessed by the Administrator which was not reported to the Director. The CO had a compliance due date of December 1, 2017. The licensee was ordered to:

“ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.”

A CI report was submitted by the home to the Director on November 30, 2017, which outlined how on the same day resident #003 went missing for greater than three hours, returning to the home with a laceration and bruise to their face.

Inspector #609 reviewed resident #003’s progress notes and found that on October 25, 2017, RN #109 documented that the resident had left the home with their brothers despite the home being aware of potential financial abuse by the brothers toward resident #003.

During an interview with RN #109 they outlined how the Administrator had instructed them not to allow resident #003’s brothers to take them on leave of absence when or if they came to the home intoxicated. When this occurred they would get the resident intoxicated and take their pension money.

During an interview with resident #003, they would not provide any details but verified that they had to change from a paper pension cheque to direct deposit related to past concerns with their money.

A review of the home’s policy titled “Resident Safety” last revised October 2017 indicated that any person who had reasonable grounds to suspect that misuse or misappropriation of a resident’s money was to report the suspicion and information upon which it was based to their Supervision, DOC or Administrator. The policy failed to mention that the person reporting the suspicion or that the leadership informed of the suspicion were to make a report to the Director.

During an interview with the Administrator they at first denied any awareness of potential financial abuse of resident #003, only to change their response later in the interview to that they were aware of potential financial abuse by resident #003's brothers. The Administrator verified that they did not report the suspicion nor the information upon which it was based to the Director.

The scope of this issue was determined to have been isolated to one incident of the Administrator who did not immediately report the suspicion to the Director. There was a previous Compliance Order (CO) issued related to this provision during inspection #2015-332575-0004 on May 22, 2015, another during #2015-283544-0023 on January 28, 2016, and a Voluntary Plan of Correction (VPC) during inspection #2016-395613-0003 on May 19, 2016. This was followed with another CO during inspection #2017-562620-0007 on June 28, 2017, with a current outstanding CO during inspection #2017-615638-0017 on October 24, 2017. The severity was determined to have been potential for actual harm to the health, safety and well-being of residents when suspected abuse and neglect are not reported to the Director. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_615638_0017, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 15 (1). Specifically, the licensee shall:

a) 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.

b) Ensure that all staff involved in the assessment of bed rails are trained and are familiar with the “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards” and “Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities and Health Care Facilities” guidance documents.

c) Perform a review of all residents and their bed systems to ensure that the plans of care accurately reflect the use of bed rails. The home will maintain a record of the required review.

d) Implement a process to ensure that registered staff notify the maintenance staff to assess the resident's bed system prior to the use of bed rails. The process will require the home to track which residents and bed systems need assessment or reassessment.

e) Ensure that registered staff assess and document the assessment of the resident prior to the use of bed rails.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, (a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps were 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 were addressed, including height and latch reliability.

During inspection #2017-615638-0017, CO #001 was served to the licensee on

October 24, 2017, related to bed rail and bed system evaluations. The CO had a compliance due date of December 1, 2017. The licensee was ordered to:

“a) Ensure that where bed rails are used, the resident is assessed and their bed system is evaluated.
b) Obtain and utilize a bed entrapment tool to evaluate every bed systems where bed rails are used.
c) Develop and implement a process to ensure that a full bed rail entrapment assessment is completed for every bed system with bed rails in accordance with the Health Canada guidance document “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards”
d) Maintain a record for each bed system evaluated, which includes; the zones of entrapment tested, what the results were, which bed systems failed the entrapment test and what actions or interventions put in place to immediately eliminate the risk to the resident.”

While the licensee complied with sections “b” and “d” non-compliance continued to be identified with section “a” and “c” where the licensee was ordered to evaluate bed systems where rails were used as well as develop a process to ensure bed rail assessments were completed using the “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards” clinical document as a guide.

a) Inspector #684 observed the two most recent residents admitted to the home and found resident #004 had one bed rail engaged while resident #005 had two bed rails engaged.

During interviews with resident #004 and #005 they both verified that bed rails had been used on their beds since being admitted to the home.

During an interview with resident #004’s Substitute Decision Maker (SDM) they verified that the bed rail had been in place and engaged since before Christmas 2017 while resident #005’s emergency contact believed that the bed rails were engaged since the resident’s admission on January 9, 2018.

A review of the home’s policy titled “Resident Services Manual- subsection 4.1.3 C Bed Rails” last revised November 2017 required residents be assessed prior to the use of bed rails.

A review of the health care records of resident #004 and #005 found that the "Restraint: Side Rail Utilization Assessment Form" for both residents was completed on February 5, 2018, two months after resident #004 was admitted and one month after resident #005 was admitted.

A review of the plans of care for resident #004 and #005 found neither care plan had been updated to indicate the residents used bed rails.

During an interview with the DOC, they verified that residents should have been assessed prior to the use of bed rails and that the use of bed rails should have been documented in the residents' plans of care.

b) Inspector #684 observed the two most recent residents admitted to the home and found resident #004 had one bed rail engaged while resident #005 had two bed rails engaged.

During interviews with resident #004 and #005 they both verified that bed rails had been used on their beds since being admitted to the home.

During an interview with Maintenance staff member #013, they verified that they were trained in the use of the bed entrapment tool and that the assessment would be documented on the "Bed System Measurement Device Test Results Worksheet". They further verified that neither resident #005 nor resident #004's were evaluated as the registered staff had not made them aware that the residents were using bed rails.

Inspector #684 reviewed the home's policy titled "Resident Rights and Safety-subsection 4.1.3b Bed Entrapment Prevention Program" last revised October 2017 which indicated that residents were assessed for risk associated with bed rail use on admission.

During an interview with the Administrator, they verified that prior to any resident using bed rails there should have been a "Restraints: Side Rail Utilization Assessment" conducted by the registered staff and a "Bed System Measurement Device Test Results Worksheet" completed.

c) During an interview with the Maintenance Manager #101, they indicated that they did not know when bed rails were to be assessed or reassessed and stated that the home required a tracking process to keep up with the assessments that

needed to be completed.

During interviews with the Maintenance Manager and Maintenance staff member #108 (responsible for the bed system evaluation), both indicated that they were unaware of the “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards” or “Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities and Health Care Facilities” guidance documents.

The scope of this issue was determined to have been isolated to two residents observed without bed rail assessments. There was a previous Written Notification (WN) issued related to this provision during inspection #2015-332575-0004 on May 22, 2015, and a CO during inspection #2015-562620-0007 on June 28, 2017. This was followed with another outstanding CO during inspection #2017-615638-0017 on October 24, 2017. The severity was determined to have been potential for actual harm to the health, safety and well-being of residents not adequately assessed for bed rail use. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2018

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2017_615638_0017, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 30 (1). Specifically, the licensee shall:

a) Ensure that the home's Nutrition and Hydration Program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

b) Specifically ensure that the Nutrition and Hydration Program is consistent with O. Reg 79/10, s.68., and 69.

c) Ensure that the home's Dietitian is involved in the evaluation, implementation and ongoing review of the Nutrition and Hydration Program.

Grounds / Motifs :

1. The Licensee has failed to ensure that the following was complied with in respect to the organized Nutrition and Hydration Program: There must be a written description of the program that included its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and a written record kept relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During inspection 2017-615638-0017 CO #002 was served to the licensee on October 24, 2017, related to the organized programs required under section 8 to 16 of the Act and section 48 of the Regulation. The CO had a compliance date of December 1, 2017, and ordered the home to:

"ensure the following programs be evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: a) Falls Prevention Program, ensuring that the program is consistent with O.Reg 79/10, s.49., b) Skin and Wound Care Program, ensuring that the program is consistent with O. Reg. 79/10, s.50., c) Continence Care and Bowel Management Program, ensuring that the program is consistent with O.Reg.79/10, s.51., and d) Nutrition and Hydration Program, ensuring that the program is consistent with O. Reg 79/10, s.68., and 69."

While the licensee complied with sections “a”, “b”, and “c” non-compliance continued to be identified with section “d” where the licensee was to evaluate and update their Nutrition and Hydration Program in accordance with evidence-based practices.

During interviews with the Dietary Manager and the Administrator, Inspector #684 requested the Nutrition and Hydration Program policy and procedure and was provided a policy for Feeding and Hydration specifically Feeding and Hydration Protocols as well as the Nutritional Services Manual which was last reviewed November, 2013. They failed to produce any documentation supporting a Nutrition and Hydration Program.

During an interview with the Dietitian they denied being involved in any evaluation of the Nutrition and Hydration Program.

During an interview with the DOC they verified that the Nutrition and Hydration Program had not been evaluated despite the passing of two months since the compliance due date.

The scope of this issue was determined to have been widespread lack of documentation, review or revision of the Nutrition and Hydration Program. There was a previous CO issued related to this provision during inspection #2017-562620-0007 on June 28, 2017. This was followed with another outstanding CO during inspection #2017-615638-0017 on October 24, 2017. The severity was determined to have been potential for actual harm to the health, safety and well-being of residents without a documented and evaluated Nutrition and Hydration Program. (684)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2018

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_615638_0017, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 99. Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (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 and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 99. Specifically, the licensee shall:

a) Ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

b) Ensure that all information related to any incident or suspicion of abuse or neglect of a resident is documented, tracked and immediately accessible to inspectors and all leadership in the home involved in the investigating and reporting of abuse or neglect of residents.

Grounds / Motifs :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

During inspection #2017-615638-0017, CO #003 was served to the licensee on October 24, 2017, related to the evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents.The CO had a compliance due date of December 1, 2017. The licensee was ordered to:

"a) Ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it.
b) Ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.
c) Ensure that the results of the analysis undertaken under clause (a) are considered in the evaluation.
d) Ensure that the changes and improvements under clause (b) are promptly implemented.
e) Ensure that a written record of everything provided for in clauses (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 and improvements were implemented is promptly prepared."

While the licensee complied with sections "a", "b", and "e", non-compliance continued to be identified with section "c" and "d", where the licensee was ordered to ensure that the analysis of every incident of abuse or neglect of a resident was considered in the evaluation as well as ensure that the changes and improvements identified in the evaluation were implemented promptly.

a) On February 5, 2018, Inspector #609 requested the home's 2017 evaluation of the zero tolerance of abuse and neglect of residents policy and was provided with the "Preventing Abuse and Neglect Program: Annual Assessment Tool" dated October 20, 2017.

A review of the annual assessment tool found no mention nor consideration of any analysis of any incident of abuse or neglect of a resident that the home was aware of in the evaluation of the policy.

The 2017 evaluation of the zero tolerance of abuse and neglect of residents policy indicated that incidents were not tracked and therefore their analyses were not considered in the evaluation.

A review of the home's policy titled "Resident Safety" last revised October 2017 required the results of the analysis of each incident of abuse or neglect of a resident be considered during the annual evaluation.

A review of the home's Plan of Corrective Action provided by the Administrator indicated that a review of all incidents of abuse and neglect were to be considered in the annual evaluation and that this had a target date of October 20, 2017.

During an interview with the Administrator the requirements under CO #003 were reviewed. The Administrator indicated that only in the 2018 annual evaluation of the zero tolerance of abuse and neglect of residents policy would the analyses of the 2017 incidents be considered and that this would occur sometime in October 2018.

b) A Further review of "Preventing Abuse and Neglect Program: Annual Assessment Tool" dated October 20, 2017, found that the home had identified that tracking of incidents of abuse or neglect of residents were to be implemented.

A review of the home's policy titled "Resident Safety" last revised October 2017 required that changes and improvements to the policy and practice were promptly implemented.

During an interview with the Administrator they outlined the improvement identified in the 2017 annual evaluation was for the home to begin tracking incidents of abuse and neglect of residents for consideration during the next annual evaluation.

The Administrator indicated that the tracking of abuse and neglect incidents would start in October 2018 or one year after the improvement was identified.

The scope of this issue was determined to have been a pattern of inaction related to the home's abuse policy evaluation. There was a previous CO issued related to this provision during inspection #2017-562620-0007 on June 28, 2017. This was followed with another outstanding CO during inspection #2017-615638-0017 on October 24, 2017. The severity was determined to have been potential for actual harm to the health, safety and well-being of residents without an evaluated or updated zero tolerance of abuse and neglect of residents policy. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 06, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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

Issued on this 23rd day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Chad Camps

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