Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Nov 14, 2014	2014_301561_0015	H-000898-14	Resident Quality Inspection

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

GRACE MANOR
45 Kingknoll Drive BRAMPTON ON L6Y 5P2

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

DARIA TRZOS (561), DIANNE BARSEVICH (581), LALEH NEWELL (147), LEAH CURLE (585), VALERIE GOLDRUP (539)

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): July 16, 17, 18, 21, 22, 23, 24, 25, and 28, 2014.

The following log number was completed during this inspection: H-000864-14. The following follow-ups were completed during this inspection: H-000453-14, H-000454 -14 and H-000915-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), Resident Assessment Instrument (RAI) Coordinator, Registered Nursing staff including Registered Practical Nurses (RPN) and Registered Nurses (RN), Personal Support Workers (PSW), Wound Care Nurse, Social Worker, Resource Nurse, Food Service Manager, Cook, Dietary Staff, Maintenance staff, Activation Manager and staff, Human Resources staff, residents and family members of residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Training and Orientation

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

- **15 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 46.	CO #002	2014_215123_0001	561
O.Reg 79/10 s. 8. (1)	CO #001	2014_215123_0001	147

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring or residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A) The nursing policy and procedure for Falls Protocol, No. 30.06.13, issued July 2, 2009 stated the following: "If the assessment identifies the resident as a medium or high risk for falling, they will be identified as such by placing the correct coloured leaf-on their wheelchair/walker/cane/; doorway of their room; on their place setting in the dining room and on the spine of their chart." "A red leaf indicates a high risk of falling."

Resident #037 experienced multiple falls within the last year. The resident was assessed as being at a high risk for falls. The red leaf could not be located on the resident's wheelchair or place setting. A PSW confirmed that there was no red leaf on the wheelchair or place setting.

Resident #005 experienced multiple falls within the last year. The resident was assessed as being at a high risk for falls. The red leaf could not be located on the resident's chart or on their place setting. A member of the registered staff confirmed that there was no red leaf in place in the identified locations.

Resident #031 experienced multiple falls within the last year. The resident was assessed as being at a high risk for falls. The red leaf could not be located on the resident's walker, door or place setting. A member of the registered staff confirmed that there was no red leaf in place on three of the four designated spots.

The home did not consistently follow the Falls Protocol for residents at risk of falls.

B) The nursing policy and procedure for Head Injury routine, No. 30-04-03, issued June 16, 2008, reviewed October 30, 2013 stated the following: " 1. Monitor the following: blood pressure, pulse and respirations, pupil and hand grip every fifteen minutes for the first hour. 2. If stable, monitor and record vital signs every hour for the next three hours. 3. If vital signs remain stable, monitor and record every four hours for twenty-four hours."

Resident #037 experienced multiple falls between November, 2013 and June, 2014 that resulted in the initiation of a head injury routine. For four of the falls head injury routines were not fully completed.

Resident #005 experienced multiple falls between September and November, 2013 that resulted in the initiation of a head injury routine. The head injury routines were not fully completed for all of the falls.

Resident #400 experienced falls resulting in the initiation of a head injury routine in June, 2014. The head injury routines were not fully completed.

A Registered staff confirmed that the routine should be completed as per the policy when initiated. The home did not consistently follow the Head Injury routine process when a resident fell.

C) The nursing policy and procedure for Resident Fall With No or Minor Injury, No. 30.06.11, issued November 20, 2008, reviewed June 18, 2013 stated the following: "Inform family of the incident and the resident status".

Resident #037 experienced multiple falls within the last year. During record review, for 6 of the falls, it was not documented that the family was notified of the resident's falls.

Resident #005 experienced multiple falls within the last year. During record review of the fall in November, 2013 it was not documented that the family was notified of the resident's fall.

Resident #400 experienced multiple falls within one month in 2014. During record review, it was not documented that the family was notified of the resident's fall.

A registered staff confirmed that the family of a resident who had fallen should have been contacted and the contact documented in the electronic records.
The home did not consistently follow the Falls Protocol for residents and inform the next-of-kin when a fall occurred and document the contact.

D) The nursing policy and procedure for Falls Protocol, No. 30.06.13, issued July 2, 2009 stated the following: "The Falling Leaf program has been implemented and will be kept up to date to enhance the resident's safety and reduce the number of falls and falls related injuries."

However, only residents that had "fallen and has a severe injury" according to the nursing policy and procedure for Resident Fall with Severe Injury, No. 30.06.12, issued November 20, 2008, reviewed June 18, 2013 were referred to the Fall/Restraint team.

Resident #005 experienced multiple documented falls within the last year.

Resident #037 experienced multiple falls between August, 2013 and June, 2014.

Resident #400 experienced multiple falls within one month in 2014. One of the falls resulted in an injury. The family and physician were contacted, resident was transferred to hospital and subsequently passed away.

Minutes of the Falls Meetings held in October 2013 and April 2014 were reviewed and residents #005, #037 and #400 were not named.

There was no clear direction to staff to follow-up, evaluate and refer residents who have fallen repeatedly without severe injury.

E) The nursing policy and procedure for Resident Fall with Severe Injury, No. 30.06.12, issued November 20, 2008, reviewed June 18, 2013 stated the following for when a resident has "fallen and has a severe injury". "The Fall/Restraint team is to meet quarterly to discuss falls and preventative measures for the resident safety. The team is to include the physician, pharmacist, physiotherapist and nursing staff".

Meetings had been held October, 2013 and April, 2014. The ADRC confirmed the meetings had not occurred quarterly and were now scheduled to occur quarterly with all members in attendance.

F) The nursing policy and procedure for Resident Fall With No or Minor Injury, No. 30.06.11, issued November 20, 2008, reviewed June 18, 2013 and the nursing policy and procedure for Resident Fall with Severe Injury, No. 30.06.12, issued November 20, 2008, reviewed June 18, 2013 identified that a fall should be documented under the Risk Management section.

Falls Team Meeting minutes dated September 5, 2013 identified that when there was a change in status with a resident, using the above tool, there is no alert system to inform all the disciplines and the Falls policies "need(ed) to be reviewed".

The policy had not been reviewed and updated to ensure that all fall prevention strategies including interdisciplinary referral and review occurred when a resident had fallen. [s. 49. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee did not ensure there was a written plan of care for each resident that sets out, clear direction to staff and others who provide direct care to the resident.

A) Resident #040 had a fall in 2014 while a private sitter was portering the resident and

the footrests were not applied on the wheelchair. The Falls Prevention Follow up note indicated the following: "staff to remind the sitter to ensure that the wheelchair is in good condition and footrest is in place before portering". The MDS RAP indicated that the written plan of care had been updated with the recommendations made by the interdisciplinary team to ensure that staff and private sitter knew that the resident's foot rest should be on at all times when the resident was in the wheelchair. Interview with RAI Coordinator confirmed that the recommendations made during the Post Fall Follow up were to be added to the written plan of care by the Resource Nurse. The written plan of care and kardex were reviewed and did not include the recommendations made by the interdisciplinary team. The written plan of care and the kardex did not provide clear direction to staff and the private sitter.(561)

B) Resident #040 was observed to have upper and lower dentures. The written plan of care and kardex were reviewed and did not indicate that the resident had dentures or any interventions related to oral care. Registered staff confirmed that the resident had dentures and they required assistance with denture care. The plan of care did not provide clear direction to staff related to denture care.(561)

C) Resident #016 had a plan of care to wear a green stripe pad during the day, and a purple stripe pad at night. The resident's kardex stated they required a purple stripe pad at night. The continence product form, accessible to all staff, stated the resident required a green pad when awake, and a purple pad when in bed. Two PSWs stated resident had required purple stripe pads at all times for approximately one year. Interview with registered staff confirmed resident required purple stripe pads at all times, and that the kardex, plan of care, and continence product form did not set out clear direction to staff. (585)

D) The Minimum Data Set (MDS) assessment completed for resident #039, indicated the resident had dentures and required extensive assistance of one person to provide for their oral hygiene needs. The kardex did not indicate if the resident had dentures and did not provide clear direction to the personal support workers what interventions were required to provide for the resident's oral and denture care needs. The registered staff and the personal support worker confirmed the resident required extensive assistance with oral and dental care and the plan of care did not provide clear directions to staff.

E) Resident #013's plan of care and kardex indicated that the resident required a brief with liner. Review of the resident continence product form that was posted in the clean utility room and in the Quality Life binder indicated that the resident required a purple pad

when awake and in bed, medium tab briefs and a contour liner. Interview with the personal support workers stated that the resident wears a purple pad during the day with no liner and a large pink tab brief with a liner at night.

F) Resident #025's plan of care and kardex indicated that the resident required a brief with tabs or purple stripe and at night required a booster liner. Review of the resident continence product form indicated that the resident required a large tab when awake and a medium tab when in bed and a contour liner. The PSW stated the resident required a large pink tab brief during the day and a large pink tab brief with a liner at night. The registered staff and PSWs confirmed that resident #013's and #025's continence product list were not updated to reflect the residents care needs and there was no clear direction provided to the front line staff on the plan of care or kardex on what type and size of brief or pad was needed to provide bowel and bladder continence care.

G) Review of the plan of care indicated that resident #025 received a tilted wheelchair to improve posture, positioning and comfort. Observation of the resident and the PSW stated the resident had a table top placed on their tilt wheelchair at all times when up as the resident uses the table top to read their books. Review of the document that the home refers to as the care plan revealed there was no care plan in place to address the resident was positioned in a tilt wheelchair and when the table top was to be applied. The kardex and the written plan of care did not indicate the resident had a table top for their wheelchair and that the PSW applied the table top when the resident was up in the wheelchair. The registered staff and the PSW confirmed that the plan of care and kardex did not provide clear direction to staff to place the table top on the tilt wheelchair so the resident can read their books. [s. 6. (1) (c)]

2. The licensee did not ensure that staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

A) Resident #037 had a Mini Mental Status Examination (MMSE) completed in 2014. The resident scored 15/30 which indicated moderate impairment. The registered staff documented the following in progress notes; "MMSE done and res scored 15/30 indicates moderate impairment. Charge nurse notified and info in MD binder". The resident then had an annual physical examination at which time the physician documented that the resident had "mild cognitive impairment". The plan of care regarding the "resident's chronic/ progressive decline in intellectual functioning related to function"

had not been updated since 2010. A registered staff confirmed the information regarding the MMSE score should have been added to the plan of care. The staff did not collaborate in the update of the written plan of care.(539)

B) A review of resident #025's written plan of care for toileting indicated that staff were to use a toileting sling with full lift after the resident was readmitted from hospital in 2014. A review of the Resident Assessment Protocol (RAP) indicated that due to poor trunk control and weakness the resident was not being toileted and was changed in bed. The PSW confirmed the resident was not able to be toileted due to poor balance and was changed in bed. An interview with the Resident Assessment Instrument (RAI) Coordinator confirmed that there was no collaboration between registered staff and the RAI Coordinator in the assessment of the residents care needs related to toileting the resident. [s. 6. (4) (a)]

3. The licensee did not ensure that the plan of care was reviewed and revised at the time when the resident's care needs changed.

Resident #021 had a pressure ulcer. The current written plan of care indicated that the resident had an air mattress for pressure relief. The intervention was initiated in February, 2014. Inspector observed that the resident did not have an air mattress on their bed. The progress notes specific to skin issues, stated that resident was no longer on an air mattress. Registered staff confirmed that the written plan of care was not revised when the air mattress was removed and a pressure guard mattress was put in place. Staff also identified the use of pressure relieving booties and a soft pillow under resident's feet for comfort. None of these interventions were included in resident's written plan of care or kardex. Registered staff confirmed that the written plan of care and kardex had not been updated and proceeded to make the corrections. [s. 6. (10) (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 there is a written plan of care for each resident that sets out, clear direction to staff and others who provide direct care to the resident and to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and to ensure that the plan of care is reviewed and revised at the time when the resident's care needs change., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that doors leading to non-residential areas were locked when they were not being supervised by staff.

On July 16, 2014, a housekeeping room, located on the first floor unit, was found unlocked and unsupervised. Cleaning products were present in the room, including bottles of bleach, bug killer, enzymes, and disinfectant. A PSW walked by and stated the keys belonged to the housekeeper, and the door should have been locked. The PSW walked away and left the door unlocked. The PSW returned, stating that the housekeeper must have forgotten their keys, then walked away and left the door unlocked. A housekeeper arrived to the room and confirmed the door was unlocked and unattended for 15 to 20 minutes. The housekeeper confirmed the presence of chemicals in the room. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that doors leading to non-residential areas are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: 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 did not ensure that where bed rails are used, the resident was assessed and their 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.

On July 23, 2014 resident #013 was observed in bed with one quarter bed rail and one three quarter bed rail raised.

On July 17 and July 25, 2014 resident #025 was observed in bed with one three quarter and one quarter bed rails raised and was observed on July 22, 2014 with one quarter bed rail raised.

On July 23, 2014 resident #037 was observed in bed with one quarter and one three quarter bed rail raised.

On July 23, 25, 2014 resident #039 was observed in bed with two quarter rails raised.

On July 23, 2014 resident #040 was observed in bed with one quarter bed rail raised.

On July 23, 28, 2014 resident #301 was observed with one quarter bed rail raised.

On July 23, 28 2014 resident #305 was observed with one three quarter bed rail raised.

The plans of care for residents #013, #025, #037, #039, #040, #301, #305 were reviewed and there were no bed rail assessments found in the plan of care. Registered staff and personal support workers stated that the residents did have bed rails on their bed for safety and positioning. The Director of Resident Care confirmed that no bed rail assessments have been completed in the home to determine if the bed rails were being used as a Personal Assistance Services Device (PASD) or a restraint and that the home was going to evaluate the residents' bed systems in the future. The Administrator confirmed that the home had not assessed any of the bed systems since the home opened to minimize risk to the residents. [s. 15. (1) (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 where bed rails are used, the resident is assessed and their bed system is evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident-staff communication and response system could be easily seen, accessed and used by residents, staff and visitors at all times.

A) Resident #036's call bell was observed sitting on the back of the toilet tank on multiple days in July, 2014. When sitting on the toilet the resident could not reach the call bell.

The resident confirmed that he would not be able to reach the call ball if he needed it in an emergency.(539)

B) The third floor shower rooms were observed to have the toilet call bell cords strung horizontally along the wall, held up by three round brackets. A PSW stated the cord was positioned as such to have it within reach of the toilet. When the bell cord was pulled, it required strong force to activate the call bell. Maintenance staff was not sure if a weak resident would be able to activate the call bell. PSWs on both floor areas stated that a weak resident would not have enough strength to pull and activate the call bell.(585)

C) On third floor north shower room, and on third floor south shower room, it was observed that the shower call bells were wrapped around the shower bar. The bell did not ring when the handle was pulled, as there was no slack on the cord. PSWs on both floor areas confirmed the cord was not to be wrapped around the bar and a resident would not be able to activate it.(585)

D) On July 16, 2014, a washroom located on the first floor adjacent to the elevator was found unlocked and unsupervised, and did not contain a resident-staff communication and response activation station. On July 21 and 22, 2014, washrooms on first, second, and third floor adjacent to the elevators were found unlocked and unsupervised, and did not contain a resident-staff communication and response activation station. The washrooms were located in a common space, which could be easily accessed residents, staff and visitors.(585)

E) In July, 2014 resident #040 was observed sitting in a wheelchair in their room away from the bed watching TV. The call bell was on the bed and not within reach of the resident. The PSW confirmed that when staff brought the resident back from an activity they forgot to place the call bell within resident's reach. The written plan of care stated "call bell must be within reach of the resident when in room". The home did not ensure that the call bell was easily accessed by resident at all times.(561)

F) On July 25, 2014 resident #031 was observed sitting on the side of their bed eating a morning snack with their walker in front of them. The call bell was observed to be attached to the chair against a far wall and not within reach of the resident. The nursing policy and procedure for Call Bells, No. 60-09-08, issued June 23, 2008, stated the following: "The functioning call bell must always be within reach of the resident". [s. 17. (1) (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 the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

Alternatives to the use of a PASD had been considered and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

A) Resident #040 was observed in bed and had a quarter bed rail applied on one side. The review of resident's health records indicated that there was no assessment done and the home did not ensure alternatives have been considered. The registered nursing staff reported that no bed rail assessment was completed for this resident.(561)

B) Resident #025 was observed sitting in a tilt wheelchair with table top. Review of the clinical record indicated that the resident received the tilt wheelchair in June, 2014 and was not assessed if the tilt wheelchair and/or table top was being used as a PASD. The DRC and the registered staff confirmed that resident #025's assessment was not completed at the time they received the tilt wheelchair to determine if the tilt wheelchair was being used as a PASD or restraint.(581)

C) Resident #040 was observed sitting in a tilt wheelchair. Interview with staff indicated that the resident has been tilted since they received a new wheelchair. Review of the clinical record and interview with ADRC confirmed that the resident was not assessed to determine that the tilt wheelchair was being used as a PASD or restraint.(561)

D) Resident #036's room was observed during Stage 1 of the RQI. Both quarter bed rails were observed in the up position. On July 28, 2014, one quarter rail was observed in the up position, however the licensee did not ensure alternatives had been considered. The registered nursing staff and DRC confirmed that no bed rail assessments was completed to determine if the bed rails were being used as a PASD or restraint. (539)

E) Resident #013, #025 were observed with one quarter rail and one three quarter rail raised, resident #301 with one quarter bed rail raised, resident #304 and #305 with three quarter bed rail raised, however the licensee did not ensure alternatives have been considered and that a bed rail assessment was completed. The registered nursing staff and DRC confirmed that no bed rail assessments were completed to determine if the bed

rails were being used as a PASD or as a restraint.(581)

2. The licensee did not ensure that the use of the PASD had been approved by, i. a physician, ii. A registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapist of Ontario, v. a member of the college of Physiotherapist of Ontario, or vi. Any other person provided for in the regulations.

A) Clinical documentation for residents #013,#025, #036, #040, #301, #302, #303, #304 and #305 was reviewed and there were no documented approvals for the use of the bed rails as a PASD or restraint. The registered nursing staff and DRC confirmed there were no approvals for the use of the bed rails as PASDs or restraints.(561)(581)(539)

B) Review of the clinical records for resident #025 indicated there was no documented approvals for the use of the tilt wheelchair and table top as a PASD or restraint. The DRC and the registered nursing staff confirmed there were no approvals for the use of the tilt wheelchair and table top as a PASD or restraint.(581)

C) Review of the clinical records for resident #040 indicated there was no documented approval for the use of the tilt wheelchair as a PASD or restraint. The ADRC and the registered nursing staff confirmed there were no approvals for the use of the tilt wheelchair as a PASD or restraint. The ADRC stated that consent was received from the substitute decision maker for the use of the tilt wheelchair as a PASD on July 25, 2014. (561)

3. The licensee did not ensure that the use of the PASD was consented to by the resident or, if the resident is incapable, a substitute decision maker (SDM) of the resident with authority to give consent.

A) Residents #013, #025, #036, #040, #301, #304 and #305 or their SDM did not provide consents for the bed rails to be used as PASDs or restraint.
The DRC, registered staff and the clinical record confirmed the bed rails were not consented as a PASD. [s. 33. (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 use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD had been considered and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
3. The use of the PASD had been approved by, i. a physician, ii. A registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapist of Ontario, v. a member of the college of Physiotherapist of Ontario, or vi. Any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker (SDM) of the resident with authority to give consent., to be implemented voluntarily.

WN #7: 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 did not ensure that staff used safe transferring and positioning devices or techniques when assisting the resident.

Resident #040 had a fall while a private caregiver was portering the resident. Resident's feet got caught on carpet and they fell forward out of the wheelchair. The fall resulted in an injury to the resident.
The investigation report and the DRC confirmed that the factors contributing to the fall were an untrained sitter and no foot rest on wheelchair while portering. The home did not ensure that the private caregiver used safe transferring devices and techniques when assisting the resident. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 94. Volunteer program

Specifically failed to comply with the following:

s. 94. (2) Every licensee of a long-term care home shall ensure that a staff member monitors or directs a volunteer whenever it is necessary to ensure the safety of a resident. O. Reg. 79/10, s. 94 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a staff member monitors or directs a volunteer wherever it is necessary to ensure the safety of a resident.

During lunch meal service on two days in July 2014, volunteers were barbecuing and assembling burgers and hot dogs for residents of the first floor south wing. The volunteers stated the only instruction they received from the home was to cook the meat to 72 degrees Celcius. They stated they had not received training on how to cook and handle foods, or record food temperatures. The staff monitoring the volunteers confirmed the home did not have an established process in place to ensure meals prepared by volunteers met the food production and handling requirements of the dietary department. No dietary staff were present to monitor or direct the volunteers for safe food preparation and handling to ensure the safety of the residents. [s. 94. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a staff member monitors or directs a volunteer wherever it is necessary to ensure the safety of a resident., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Resident #300 requested assistance with toileting. A PSW assisted the resident to a shared washroom in a common area adjacent to the lounge and dining room. The PSW entered the washroom with the resident, and closed the door. The PSW then stepped out of the washroom while the resident was toileting, and kept the door partially open for over a minute by leaning up against it. The PSW stated that the resident required some assistance with toileting, that the home's expectation was to close doors when assisting residents with toileting, and that another PSW was nearby when the door was open. A Registered Nurse confirmed that staff are expected to close doors when toileting residents to provide privacy. [s. 3. (1) 8.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue, that includes, mouth care in the morning and evening, including cleaning of dentures.

Resident #039 stated that personal support workers did not brush their dentures with toothpaste and only rinsed and put them in the denture cup to soak. The resident stated that their dentures were very dirty and needed thorough cleaning to remove all the food particles. The written plan of care and kardex stated the resident needed extensive assistance of one staff but did not indicate how denture care was to be provided for the resident. [s. 34. (1) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 did not respond in writing within ten days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council Meeting Minutes from January, 2014 until June, 2014 identified that not all concerns or recommendations received were responded to in writing within ten days.
Meeting minutes for January, 2014 included a request that memorial services be taped and viewed during the service so they can be watched in the lounge, a clock be put in three south dining room and menu options in the restaurant were advertised in advance so the residents can make a choice before going to the restaurant. The Administrator responded in writing to the Residents' Council fourteen days later.

Meeting minutes for February, 2014 included a question related to accommodation rates, a concern that residents, family members, visitors do not have updated access to the names of the staff on the unit for each shift and on the family board, staff did not know where family members could buy meal tickets and a concern about missing laundry. The Administrator responded in writing to the Residents' Council fifteen days later.

Meeting minutes for March, 2014 included a question about outdoor gardening and accessibility for residents in wheelchairs, a concern about missing clothing and a request to move the clock to a better location. The Administrator responded in writing to the Residents' Council fifteen days later.

Meeting minutes for June, 2014 included a question about when the balcony on three south would have a latch system in place and whether upbeat music could be provided on the units. These concerns were not responded to by the licensee.

Interview with the Resident Council Assistant confirmed that written responses to concerns, questions and recommendations were not always completed and/or not completed within ten days. [s. 57. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee did not respond in writing within ten days of receiving Family Council advice related to concerns or recommendations.

A review of the Family Council Meeting Minutes from November, 2013, February, April, and June, 2014 identified that not all concerns or recommendations received were responded to in writing within ten days.

Meeting minutes from November, 2013, included a concern from a family member that it was difficult to obtain and purchase a meal ticket to enjoy a meal with their family member. The Administrator did not respond in writing until January, 2014.

Meeting minutes from February 8, 2014 included a concern that TV channel 989 had advertisements on it and some inappropriate songs on the channel. There was another concern that the handicap parking sign was missing, that family and friends still find it difficult to buy meal tickets and that the seating areas in the new restaurant needs to be looked at as it is difficult to maneuver walkers and wheelchairs. It was also suggested that pictures of staff be posted on the website. The Administrator did not respond in writing until March 10, 2014. There was another concern that there should be more support for Catholic residents and this concern was not responded to by the licensee.

Meeting minutes from April, 2014 included a request for more timely responses to family e-mails from management. This concern was not responded to by the licensee.

Meeting minutes from June, 2014, included a concern about the vents/deflectors in the common lounges blowing cold air directly down on the residents and a concern about activities keeping the residents' interest, having less down time and more tactile activities. There was also a concern voiced about the loss of two more parking spots and about the drop-off zone in front of Grace Manor. These concerns were not responded to by the licensee.

Interview with the Family Council Liaison and the Family Council President confirmed that written responses to concerns and recommendations were not always completed and/or not completed within ten days. [s. 60. (2)]

WN #13: 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,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

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 did not ensure that the food production system must, at a minimum, provide for, standardized recipes for all menus.

In July, 2014, garden salad was on the planned menu for lunch. Prior to meal service, a prepared salad was observed in the kitchen by the inspector. A dietary staff member reported they prepared the salad. Reviewed the recipe binder and the dietary staff and Cook and both reported no salad recipe was present. The Food Service Manager confirmed there was no recipe available for staff to follow at the time of meal preparation. [s. 72. (2) (c)]

2. The licensee failed to ensure that the food production system must, at a minimum, provide for preparation of all menu items according to the planned menu.

In July, 2014, for the lunch meal, beef patty was listed on the menu for the reducing diet. During lunch, dietary staff stated some residents on the floor followed a reducing diet; however no beef patties were prepared as per their therapeutic menu list. The Food Service Manager confirmed the reducing diet therapeutic menu included beef patty, and the menu item was not prepared according to the planned menu. [s. 72. (2) (d)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may

be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The home did not ensure the resident admission package of information included: (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; (d) an explanation of the duty under section 24 to make mandatory reports; (f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; (g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained.

The Director of Resident Care checked no to the following items on the LTCH Licensee Confirmation Checklist: Admission Process. The following items were not presently in the resident admission package.
2. c. Home's policy to promote zero tolerance of abuse and neglect of residents.
2. d. Explanation of a person's duty to make mandatory reports to the Director.
2. e. Explanation of a whistle-blowing protections related to retaliation.
2. g. MOHLTC procedure for making a complaint to the Director including the Ministry's toll-free telephone number and hours of service.
2.h. Notification of the home's policy to minimize the restraining of residents and how to receive a copy of the policy.

The Director of Resident Care confirmed that the following information had not been in the resident admission package and that it was being added by the Administrator as follow-up to the completion of the checklist. [s. 78. (2)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee did not seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Family Council Minutes were reviewed for the past eight months and there was no documentation in the minutes that included the licensee seeking the advice of the Council in the development of the satisfaction survey or in acting on its results. Interview with the Liaison for Family Council and President of Family Council confirmed that the Council had not been involved in the satisfaction survey. [s. 85. (3)]

2. The licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Residents' Council Minutes were reviewed and the minutes did not include the licensee seeking the advice of the Council in the development of the satisfaction survey or in acting on its results. Interview with the Assistant of Residents' Council confirmed that the Council had not been involved in the satisfaction survey. [s. 85. (3)]

3. The licensee did not make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Family Council Meeting Minutes were reviewed for the past eight months and did not include the results of the satisfaction survey in order to seek the advice of Council. Interview with the Family Council Liaison and the Family Council President confirmed the results of the survey were not made available. [s. 85. (4) (a)]

4. The licensee did not document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Resident Council minutes were reviewed and there was no documentation that included the results of the satisfaction survey in order to seek the advice of Council. Interview with the Resident Council Assistant confirmed the results of the survey were not made available or discussed at Resident Council meetings. [s. 85. (4) (a)]

Issued on this 5th day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561), DIANNE BARSEVICH (581), LALEH NEWELL (147), LEAH CURLE (585), VALERIE GOLDRUP (539)
Inspection No. / No de l'inspection :	2014_301561_0015
Log No. / Registre no:	H-000898-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 14, 2014
Licensee / Titulaire de permis :	HOLLAND CHRISTIAN HOMES INC 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	GRACE MANOR 45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER DYKSTRA

To HOLLAND CHRISTIAN HOMES 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the falls prevention and management program is in compliance with the legislation and must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids and that the policies for falls are followed.

The plan shall be submitted to Ministry of Health and Long-Term Care Inspector, Valerie Goldrup via email at Valerie.Goldrup@ontario.ca on or before January 30, 2015.

Grounds / Motifs :

1. The licensee did not ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A) The nursing policy and procedure for Falls Protocol, No. 30.06.13, issued July 2, 2009 stated the following: "If the assessment identifies the resident as a medium or high risk for falling, they will be identified as such by placing the correct coloured leaf- on their wheelchair/walker/cane/; doorway of their room; on their place setting in the dining room and on the spine of their chart." "A red leaf indicates a high risk of falling."

Three residents were reviewed and all three residents did not have identifier at all locations as confirmed by staff. The home did not consistently follow the Falls Protocol for residents at risk of falls.

B) The nursing policy and procedure for Head Injury routine, No. 30-04-03, issued June 16, 2008, reviewed October 30, 2013 stated the following: " 1. Monitor the following: blood pressure, pulse and respirations, pupil and hand grip every fifteen minutes for the first hour. 2. If stable, monitor and record vital signs every hour for the next three hours. 3. If vital signs remain stable, monitor and record every four hours for twenty-four hours."

Three residents were reviewed and all three residents did not have the head injury routine fully completed. Registered staff confirmed that the routine should be completed as per the policy when initiated. The home did not consistently follow the Head Injury routine process when a resident fell.

C) The nursing policy and procedure for Resident Fall With No or Minor Injury, No. 30.06.11, issued November 20, 2008, reviewed June 18, 2013 stated the following: "Inform family of the incident and the resident status".

Three residents were reviewed and all three residents did not consistently have their next-of-kin contacted after a fall. A registered staff confirmed that the family of a resident who had fallen should have been contacted and the contact documented in the electronic records.

The home did not consistently follow the Falls Protocol for residents and inform the next-of-kin when a fall occurred and document the contact.

D) Resident #005 experienced multiple falls within the last year.

Resident #037 experienced multiple falls between August, 2013 and June, 2014.

Resident #400 experienced multiple falls within one month in 2014. One of the falls resulted in an injury. The family and physician were contacted, resident was transferred to hospital but subsequently passed away.

The nursing policy and procedure for Falls Protocol, No. 30.06.13, issued July 2,

2009 stated the following: "The Falling Leaf program has been implemented and will be kept up to date to enhance the resident's safety and reduce the number of falls and falls related injuries."

However, there was no clear direction to staff to follow-up, evaluate and refer residents who have fallen repeatedly without severe injury.

E) The nursing policy and procedure for Resident Fall with Severe Injury, No. 30.06.12, issued November 20, 2008, reviewed June 18, 2013 stated the following for when a resident has "fallen and has a severe injury". "The Fall/Restraint team is to meet quarterly to discuss falls and preventative measures for the resident safety. The team is to include the physician, pharmacist, physiotherapist and nursing staff".

Meetings had been held October, 2013 and April, 2014. The Assistant Director of Resident Care confirmed the meetings had not occurred quarterly and were now scheduled to occur quarterly with all members in attendance.

F) The nursing policy and procedure for Resident Fall With No or Minor Injury, No. 30.06.11, issued November 20, 2008, reviewed June 18, 2013 and the nursing policy and procedure for Resident Fall with Severe Injury, No. 30.06.12, issued November 20, 2008, reviewed June 18, 2013 identified that a fall should be documented under the Risk Management section.
Falls Team Meeting minutes dated September 5, 2013 identified that when there was a change in status with a resident, there is no alert system to inform all the disciplines" and the Falls policies "need(ed) to be reviewed".

The policies had not been reviewed and updated to ensure that all fall prevention strategies are in place, implemented, in alignment with one another and include interdisciplinary referral and review when a resident had fallen. (539)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 14th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

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