Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 27, 2017;	2017_625133_0013 (A1)	012348-17, 013489-17	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD OTTAWA ON K1N 5M2

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

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home's Administrator requested an extension for compliance order #001, to complete all requested aspect of the order. Extension granted. New compliance due date is December 31, 2017

Issued on this 27 day of September 2017 (A1)

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

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

LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 21, 22, 23, 26, 27, 28, 29, 30, 2017, July 4, 11, 2017

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the Program Manager of Resident Care, the Program Manager of Personal Care, Registered Nurses(RN), a Family Physician, Registered Practical Nurses(RPN), Personal Support Workers (PSW), the Pharmacist, the Rehabilitation Assistant, the Building Systems Technician, the Facility Operator, the Facilities Supervisor, the Staffing Coordinator, the Enterostomal Therapy Nurse (ET Nurse), the resident, a family member, and two representatives of ArjoHuntleigh Canada Inc.

During the course of the inspection, the inspector(s) reviewed the identified resident's health care records, reviewed instruction manuals for residents' beds, reviewed documentation related a resident's bed system, reviewed service request notifications related to bed maintenance, reviewed a cleaning schedule for mobility related equipment, observed a resident's mobility device, reviewed access card report for a specified period on June 15, 2017, reviewed interview notes of Program Manager of Resident Care (PMRC) and Program Manager of Personal Care (PMPC), reviewed the following policies: Medical Directives #600:09, revision date (November 2012), Fall prevention Program, revision date (April 2017), Preventing resident falls-physical environment #900.05, revision date (June 2014), Spine Codes #325.08, revision date (June 2017) and Transfer: External: Hospital #310.04, revision date (June 2017).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Falls Prevention

Hospitalization and Change in Condition

Prevention of Abuse, Neglect and Retaliation

Safe and Secure Home

Skin and Wound Care

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

- **3 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented to ensure

that resident #001's bed was kept in good repair. The licensee has failed to ensure that procedures are developed and implemented to ensure that residents' beds are maintained at a level that meets manufacturer specifications, at a minimum.

On an identified date in June 2017, a complaint was lodged to representatives of the licensee and to the Director, in part related to the repair of resident #001's bed in that a specified portion of the bed was not functioning properly.

On June 22, 2017, Inspector #133 met with maintenance staff person #116. Maintenance staff person #116 explained that on an identified date in June 2017, which was the day following the licensee's receipt of the complaint referenced above, he had been asked by the Program Manager of Resident Care to search the computerized maintenance request program (SAP program) for anything related to resident #001's bed. Maintenance staff person #116 explained that he had found a service request notification (SRN) that had been created on an identified date in May 2017 and which had been addressed that same day, as indicated by the word "done" on the SRN. The SRN was provided to the Inspector. The SRN identified resident #001's room number, noted the problem with the specified portion of the bed, which was the same problem and portion of the bed referenced in the June 2017 complaint, and directed that the bed be repaired.

Following review of the May 2017 SRN, on the identified date in June 2017, maintenance staff person #116 explained that he then proceeded to inspect resident #001's bed. Maintenance staff person #116 explained that he had found problems with the specified portion of the bed, including as referenced in the May 2017 SRN and the June 2017 complaint. Maintenance staff person #116 explained that he repaired the problems he had found with the specified portion of resident #001's bed, and then the bed was fully functional.

On June 26, 2017, Inspector #133 met with maintenance staff person #118 with regards to the May 2017 SRN referenced above, for resident #001's bed. Maintenance staff person #118 indicated that he recalled going to look at resident #001's bed and that there was a problem with the specified portion of the bed. Maintenance staff person #118 explained that as a result of a conversation with a Personal Support Worker (PSW, #102), his understanding had been that the functionality of the specified portion of the bed was not needed for resident #001, and therefore the problem he recalled was not fixed.

Further related to the SRN, Inspector #133 reviewed a progress note within

resident #001's electronic health care record that was made by Registered Practical Nurse (RPN) #125 on the night before the SRN was created on the identified date in May 2017. Within the note, the RPN indicated that a family member of resident #001 had requested that the specified portion of the resident's bed be fixed as it was not responding. The RPN indicated that a voice mail message had been left for facility services to have the bed fixed. The May 2017 SRN was created for resident #001's bed as a result.

Inspector #133 interviewed PSW #109 and PSW #102 over the course of the inspection with regards to resident #001's bed. Both PSWs indicated that the specified portion of resident #001's bed had been inoperable since at least an identified date in May 2017, when a new mattress was put into use for the resident, thirteen days prior to the creation of the May 2017 SRN. Both PSWs indicated that they had used the function of the specified portion of resident #001's bed, for positioning the resident, during their respective shifts, prior to it becoming inoperable.

The licensee has failed to ensure that procedures were implemented to ensure that resident #001's bed was kept in good repair.

2. Related to preventative maintenance and residents' beds:

On June 22, 2017, maintenance staff person #116 explained to the Inspector that when a bedroom is vacated, the bed in the vacated room will receive a full inspection. Maintenance staff person #116 indicated that such an inspection is documented on the vacated room checklists. In addition, maintenance staff person #116 indicated that when a service request notification (SRN) is received related to a bed, the identified bed will be fully inspected, although such an inspection is not documented. Maintenance staff person #118 confirmed the above information to the Inspector on June 26, 2017.

Inspector #133 obtained Instruction Manuals for beds in use at the home from the home's Hospitality Manager (HM) on June 23, 2017. The manuals were from manufacturer MC Healthcare Products Inc. (MC Healthcare). The bed types were as follows: Valet Low Bed, MaXXum High-Low Bed and the Retractable Bed MC9R/Encore Series. The Inspector met with maintenance staff persons #116 and #118 on June 27, 2017 and they informed that there was a fourth type of bed in use in the home, a bariatric bed, from manufacturer NOA Medical Industries Inc.

(NAO Medical). Maintenance staff persons #116 and #118 qualified that there was only one of the NAO Medical bariatric beds in the home. The Inspector was provided with the Operation and Maintenance Manual for the NOA Medical bed. In addition to the one NOA Medical bariatric bed, the Inspector was informed that there was one or two of the MC Healthcare MC9R/Encore Series beds in use and that otherwise, all of the beds in use in the home were the MC Healthcare Valet Low Beds and the MC Healthcare MaXXum High-Low Beds.

Upon review of the three MC Healthcare manuals it was noted that, within the respective preventative maintenance sections, the manufacturer specified fourteen maintenance items that required inspection every six months to ensure proper functioning of the bed. The maintenance items were as follows: lubrication; motor operation; normal operation over full range; grinding, popping, other noises; bent parts; retaining rings; fasteners; cabling; power cord; caster locking; side rails; head and footboard panels; paint finish; overall appearance.

Upon review of the manual for the one NAO Medical bed in use, it was noted that within the maintenance and cleaning section, the manufacturer specified fourteen maintenance procedures that are to be performed at least once a year.

On July 11, 2017, Inspector #133 met with the home's Facilities Supervisor (FS, #126). The FS confirmed to the Inspector that preventative maintenance for residents' beds occurs when a room is vacated, which includes room transfers. As well, the FS confirmed that when a SRN is received for a bed, the bed will be fully inspected. The FS confirmed that otherwise, there is no routine preventative maintenance program in place for residents' beds. The FS explained that there was an annual work order in place related to bed maintenance, titled "valet low bed annual inspections". The FS explained that at an annual bed inspection program had not been implemented at the home. The FS indicated that he had not been aware of the manufacturer's specifications for maintenance inspections to be completed every six months for the MC Healthcare beds.

The licensee has failed to ensure that procedures were developed and implemented to ensure that residents' beds are maintained at a level that meets manufacturer specifications, at a minimum.

The non-compliance presented above is widespread in scope and presents a potential risk of harm to the residents'. As a result, a Compliance Order will be served to the licensee. [s. 90. (2) (a)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to resident #001.

Resident # 001 was admitted to the home with several diagnoses.

Resident #001's health care record was reviewed. A progress note made by the Rehabilitation Assistant (RA, #115), on an identified date in May 2017, reflected that the RA #115 had discussion with the resident's Substitute Decision Maker, who had agreed to the use of bolsters and a specified type of sheet on the mattress currently installed on resident #001's bed. RA #115 noted that he would bring up foam bolsters to the unit and inform staff that they would now be used on

the mattress.

Resident # 001's plan of care, with an identified date in April 2017, regarding "Risk of Injury from Falls", does include interventions related to the use of fall mats in a specified way, positioning of the bed in a specified way and use of pillows in a specified way. After the assessment completed by RA #115 on the identified date in May 2017, the plan of care was updated on an identified date in June 2017. The updated plan of care included interventions related to the use of bedrails and the use of bolsters in a specified way.

On an identified date in June 2017, RPN #100 called resident #001's family to inform them that the resident had fallen out of his/her bed and did not sustain any apparent injury from the fall.

On June 23, 2017, Personal Support Worker (PSW) #102 explained to Inspector #133 that about a week after a new mattress went into use, on an identified date in May 2017, he had asked RA #115 if a specified type of sheet could be used for resident #001. PSW #S102 indicated that he had explained to the RA that the type of sheet currently in use for resident #001 was "a bit slippery" with the new mattress. PSW #102 explained to the Inspector that he had noticed that resident #001 was sliding "a little bit" downwards in the bed with the type of sheet currently in use. PSW #102 indicated that he had also asked RA #115 if there was something they could use to prevent resident #001 from "going out of the bed", as the PSW had noticed that resident #001 could push himself/herself, with an identified body part, to the side. PSW #102 qualified that resident #001's bed mobility was otherwise very limited. PSW #102 indicated that RA #115 addressed these concerns immediately, and brought up two bolsters and a specified type of sheet.

On June 26, 2017, during an interview, PSW #112 indicated to Inspector #126 that on the morning of resident #001's fall from bed, on the identified date in June 2017, she was working on resident #001's care unit but was not assigned to resident #001. PSW #112 indicated that she was in the dining room when RPN#124 came and asked for assistance as resident #001 had fallen. She indicated that when she arrived in resident #001's room, she observed resident #001 to be on the floor, lying in a specified way, on the floor mat, that the bed was low and the bed rails up. She indicated that she did not recall seeing any bolsters.

On June 26, 2017, during an interview, PSW #106 indicated to Inspector #126 that

he was working the morning of resident #001's fall from bed, on the identified date in June 2017. PSW #106 indicated that he was assigned resident #001. He indicated that prior to the fall, he observed resident #001 in bed, lying in a specified way, and he noticed some redness on a specified area of resident #001's body. After feeding resident #001 his/her breakfast, PSW #106 lowered back the bed, positioned the resident at 45 degrees, put both rails up, and mats were on the floor and positioned the resident with a specified type of pillow. PSW #106, indicated that when he left the room, resident #001 was resting calmly in bed.

On June 27, 2017, during an interview, RPN #100 indicated to Inspector #126 that she administered resident #001's medications on the morning of resident #001's fall from bed, prior to the fall, on the identified date in June 2017. While she was administering the medication, she observed redness on a specified area of resident #001's body, which was the same specified area as had been observed by PSW#106. Resident #001 was observed by RPN #100 to be in bed, lying in a specified way, which was the same specified way as had been observed by PSW#106. RPN #100 observed that resident #001 was sitting up at about 45 degrees, with one half rail up on a specified side of the bed, floor mat on a specified side of the bed, bed was in a low position. When she left the room, RPN #100 indicated that resident #001 was calm and was resting in bed. Approximately thirty to fourty minutes after having administered the medications, RPN #100 heard yelling in the hallway and found resident #001 on the floor in his/her room, lying on the floor in a specified way, which was the same specified way as had been observed by PSW#112, on the floor mat. RPN #100 indicated that she could not recall seeing bolsters on the floor or in the bed.

The licensee has failed to ensure that the written plan of care for resident #001 provided clear directions to staff providing care related to the use of the bolsters and bed rails.

2. The licensee has failed to ensure that the written plan of care for resident #001 provided sets out clear directions to staff and others who provide direct care to resident #001 related to Advance Directives.

Resident # 001 was admitted to the home with several diagnoses.

On an identified date in June 2013, resident # 001 signed a Health Care Directive (HCD) that included direction that the resident's attending physician was to attempt to resuscitate the resident if the resident's heart and lungs fail.

On an identified date in April 2017, resident #001 was sent to hospital for a specified assessment and pain management. Registered Nurse (RN) #103 completed a Do Not Resuscitate (DNR) Form for resident #001 at that time.

On an identified date in June 2017, resident #001 was found on the floor beside his/her bed. As per Registered Practical Nurse (RPN) # 100's progress note, made on the day of resident #001's fall from bed, it was indicated that following the RPN's assessment, the resident was found to have no apparent injuries. Scratches on a specified area of the resident's body were also noted by RPN #100.

On the day of resident #001's fall from bed, in June 2017, resident #001 was to be sent to the hospital for an assessment. RPN #105 prepared the transfer documentation and gave the documents to the family, which included a photocopy of the DNR Form completed by RN #103 on the identified date in April 2017. The family questioned the DNR Form as resident # 001, as per the HCD, expected to be treated aggressively with resuscitation.

On June 23, 2017, during an interview, RPN #105 indicated to Inspector #126 that resident #001 was sent to the hospital on the evening of the identified date in June 2017, after the resident's fall from bed, for an assessment. RPN #105 indicated that she prepared the transfer documentation which included a photocopy of the DNR Form that had been completed by RPN #103 on the identified date in April 2017, which was given to the family. RPN #105 indicated that she was questioned by a family member regarding the DNR Form. She reviewed the health care record and noted that resident #001's HCD directed that resident #001 wished to be resuscitated. RPN #105 indicated that she notified the Program Manager of Resident Care (PMRC) related to the documentation incident related to the DNR Form.

On June 28, 2017, during an interview, RN #103 indicated to Inspector #126 that she completed a DNR Form on the identified date in April 2017, noting by error that resident #001 did not want to be resuscitated. On the identified date in April 2017, resident #001 was to be sent to the hospital and RPN #103 wanted to assist with the preparation of the transfer documentation. RN #103 indicated that it was expected that residents requiring resuscitation have a white sticker on the side of the binder (heath care record) and when she looked at the binder there was no sticker on resident #001's binder. She assumed it had fallen off the binder. As RPN #103 was preparing the documentation, she reviewed the resident's health

care record and noted the physician's "End of Life Care Form" was indicating that resident #001 wish to be resuscitated. However, RPN #103 left the DNR Form on the file and can't explain why she did not destroy the document immediately.

On June 28, 2017, during an interview, the PMRC indicated to Inspector # 126 that RN #122 contacted the Ottawa Hospital to ensure that there was no DNR Form on resident #001's file in the hospital. RN #122 indicated that she talked to Clerical Medical #124 and confirmed that resident # 001 was identified as requiring resuscitation.

The licensee has failed to ensure that the plan of care, related to Advance Directives for resident #001, set out clear directions to staff and others who provided direct care to the resident, between the identified date in April 2017 on which RPN #103 completed the DNR Form and the identified date in June 2017 on which RPN #105 notified the PMRC of the documentation incident related to the DNR Form. [s. 6. (1) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's wheelchair was kept clean.

On an identified date in June 2017, a complaint was lodged to representatives of the licensee and to the Director, in part related to the cleanliness of resident #001's wheelchair. The complaint included a picture of the specified area of concern on resident #001's wheelchair.

On June 22, 2017, Inspector #133 observed resident #001's wheelchair. It was noted that there was an accumulation of debris within the upper side section of the footrest assembly, on the right side, as per the picture provided on the identified date in June 2017. On the left side, within the upper section of the footrest assembly, the Inspector observed an area of dried yellow matter. Later that afternoon, the acting Administrator, the Program Manager of Resident Care (PMRC) and the Program Manager of Personal Care (PMPC) were informed simultaneously of the Inspector's observations and were shown pictures taken by the Inspector of the unclean areas on resident #001's wheelchair. In the presence of the Inspector, the PMRC placed a phone call to the nurses' office on resident #001's care unit and left a voice mail message, directing that the wheelchair be cleaned.

On June 26, 2017, Inspector #133 observed resident #001's wheelchair. It was noted that the wheelchair had not been cleaned. The accumulated debris and the dried yellow matter remained in place as had been observed by the Inspector on June 22, 2017. The PMPC was informed of the Inspector's observations and subsequently accompanied the Inspector to resident #001's care unit to observe

the resident's wheelchair. The PMPC acknowledged that the wheelchair had not been cleaned, and in the presence of the Inspector, he directed a Personal Support Worker (PSW) to clean the wheelchair. The PMPC explained to the Inspector that all residents' wheelchairs are scheduled for a cleaning once a month. It was documented that resident #001's wheelchair was last cleaned on June 12, 2017. The PMPC explained that in between these scheduled monthly cleanings, it is expected that nursing staff will identify any wheelchair that requires interim cleaning, and such wheelchairs will be left outside of the tub room on the evening shift for the PSW on the night shift to clean. The PMPC indicated that given what he saw in the picture of resident #001's wheelchair, on June 20, 2017, he had assumed that the wheelchair would have been left out for cleaning on the night shift. The PMPC further indicated that following the Inspector's observations on June 22nd, and the PMRC's subsequent voice mail message to resident #001's care unit, directing that the resident's wheelchair be cleaned, he had assumed that resident #001's wheelchair would have been cleaned. [s. 15. (2) (a)]

Issued on this 27 day of September 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : LINDA HARKINS (126) - (A1)

Inspection No. / No de l'inspection : 2017_625133_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 012348-17, 013489-17 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Sep 27, 2017;(A1)

Licensee / Titulaire de permis :
CITY OF OTTAWA
Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2

LTC Home / Foyer de SLD :
GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD, OTTAWA, ON, K1N-5M2

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

Ministère 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Tony Sponza

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To CITY OF OTTAWA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee is ordered to:

1. Ensure that resident #001's bed is kept in good repair.

2. Develop and implement a written procedure to ensure that residents' beds are maintained at a level that meets manufacturer specifications, at a minimum. The procedure shall include reference to manufacturer specifications for each type of bed in use in the home. The date(s) on which the specified maintenance is performed on each individual bed is to be documented.

3. Ensure that all residents' beds in the home have been maintained in accordance with the written procedure referenced above.

4. Provide documented education to all nursing staff with regards to reporting expectations and reporting methods in relation to malfunctioning beds.

5. Provide documented education to all maintenance staff on the licensee's procedure to ensure that residents' beds are repaired when a malfunction is reported.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that procedures are implemented to ensure that resident #001's bed was kept in good repair. The licensee has failed to ensure that procedures are developed and implemented to ensure that residents' beds are maintained at a level that meets manufacturer specifications, at a minimum.

On an identified date in June 2017, a complaint was lodged to representatives of the licensee and to the Director, in part related to the repair of resident #001's bed in that a specified portion of the bed was not functioning properly.

On June 22, 2017, Inspector #133 met with maintenance staff person #116. Maintenance staff person #116 explained that on an identified date in June 2017, which was the day following the licensee's receipt of the complaint referenced above, he had been asked by the Program Manager of Resident Care to search the computerized maintenance request program (SAP program) for anything related to

resident #001's bed. Maintenance staff person #116 explained that he had found a service request notification (SRN) that had been created on an identified date in May 2017 and which had been addressed that same day, as indicated by the word "done" on the SRN. The SRN was provided to the Inspector. The SRN identified resident #001's room number, noted the problem with the specified portion of the bed, which was the same problem and portion of the bed referenced in the June 2017 complaint, and directed that the bed be repaired.

Following review of the May 2017 SRN, on the identified date in June 2017, maintenance staff person #116 explained that he then proceeded to inspect resident #001's bed. Maintenance staff person #116 explained that he had found problems with the specified portion of the bed, including as referenced in the May 2017 SRN and the June 2017 complaint. Maintenance staff person #116 explained that he repaired the problems he had found with the specified portion of resident #001's bed, and then the bed was fully functional.

On June 26, 2017, Inspector #133 met with maintenance staff person #118 with regards to the May 2017 SRN referenced above, for resident #001's bed. Maintenance staff person #118 indicated that he recalled going to look at resident #001's bed and that there was a problem with the specified portion of the bed. Maintenance staff person #118 explained that as a result of a conversation with a Personal Support Worker (PSW, #102), his understanding had been that the functionality of the specified portion of the bed was not needed for resident #001, and therefore the problem he recalled was not fixed.

Further related to the SRN, Inspector #133 reviewed a progress note within resident #001's electronic health care record that was made by Registered Practical Nurse (RPN) #125 on the night before the SRN was created on the identified date in May 2017. Within the note, the RPN indicated that a family member of resident #001 had requested that the specified portion of the resident's bed be fixed as it was not responding. The RPN indicated that a voice mail message had been left for facility services to have the bed fixed. The May 2017 SRN was created for resident #001's bed as a result.

Inspector #133 interviewed PSW #109 and PSW #102 over the course of the inspection with regards to resident #001's bed. Both PSWs indicated that the specified portion of resident #001's bed had been inoperable since at least an identified date in May 2017, when a new mattress was put into use for the resident,

thirteen days prior to the creation of the May 2017 SRN. Both PSWs indicated that they had used the function of the specified portion of resident #001's bed, for positioning the resident, during their respective shifts, prior to it becoming inoperable.

The licensee has failed to ensure that procedures were implemented to ensure that resident #001's bed was kept in good repair.

2. Related to preventative maintenance and residents' beds:

On June 22, 2017, maintenance staff person #116 explained to the Inspector that when a bedroom is vacated, the bed in the vacated room will receive a full inspection. Maintenance staff person #116 indicated that such an inspection is documented on the vacated room checklists. In addition, maintenance staff person #116 indicated that when a service request notification (SRN) is received related to a bed, the identified bed will be fully inspected, although such an inspection is not documented. Maintenance staff person #118 confirmed the above information to the Inspector on June 26, 2017.

Inspector #133 obtained Instruction Manuals for beds in use at the home from the home's Hospitality Manager (HM) on June 23, 2017. The manuals were from manufacturer MC Healthcare Products Inc. (MC Healthcare). The bed types were as follows: Valet Low Bed, MaXXum High-Low Bed and the Retractable Bed MC9R/Encore Series. The Inspector met with maintenance staff persons #116 and #118 on June 27, 2017 and they informed that there was a fourth type of bed in use in the home, a bariatric bed, from manufacturer NOA Medical Industries Inc. (NAO Medical). Maintenance staff persons #116 and #118 qualified that there was only one of the NAO Medical bariatric beds in the home. The Inspector was provided with the Operation and Maintenance Manual for the NOA Medical bed. In addition to the one NOA Medical bariatric bed, the Inspector was informed that there was one or two of the MC Healthcare MC9R/Encore Series beds in use and that otherwise, all of the beds in use in the home were the MC Healthcare Valet Low Beds and the MC Healthcare MaXXum High-Low Beds.

Upon review of the three MC Healthcare manuals it was noted that, within the respective preventative maintenance sections, the manufacturer specified fourteen maintenance items that required inspection every six months to ensure proper functioning of the bed. The maintenance items were as follows: lubrication; motor

operation; normal operation over full range; grinding, popping, other noises; bent parts; retaining rings; fasteners; cabling; power cord; caster locking; side rails; head and footboard panels; paint finish; overall appearance.

Upon review of the manual for the one NAO Medical bed in use, it was noted that within the maintenance and cleaning section, the manufacturer specified fourteen maintenance procedures that are to be performed at least once a year.

On July 11, 2017, Inspector #133 met with the home's Facilities Supervisor (FS, #126). The FS confirmed to the Inspector that preventative maintenance for residents' beds occurs when a room is vacated, which includes room transfers. As well, the FS confirmed that when a SRN is received for a bed, the bed will be fully inspected. The FS confirmed that otherwise, there is no routine preventative maintenance program in place for residents' beds. The FS explained that there was an annual work order in place related to bed maintenance, titled "valet low bed annual inspections". The FS explained that at an annual bed inspection program had not been implemented at the home. The FS indicated that he had not been aware of the manufacturer's specifications for maintenance inspections to be completed every six months for the MC Healthcare beds.

The licensee has failed to ensure that procedures were developed and implemented to ensure that residents' beds are maintained at a level that meets manufacturer specifications, at a minimum.

The non-compliance presented above is widespread in scope and presents a potential risk of harm to the residents'. As a result, a Compliance Order will be served to the licensee. [s. 90. (2) (a)] (133)

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

Dec 31, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is ordered to:

1. Review and update resident #001's plan of care related to fall management that shall include clear direction related to the utilization of bolsters and bed rails to ensure resident safety.

2. Review and update resident #001's plan of care to accurately reflect the resident's instructions and wishes related to Advance Directives. Review the plans of care of all residents to ensure that any instructions for Advance Directives are clearly and accurately reflected in the plans of care and other associated health care documentation.

3. Implement fall management interventions, and assess effectiveness of the interventions on an on going basis, for resident #001.

4. Ensure clear direction is provided to all staff related to fall management and Advance Directives, for resident #001.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the plan of care sets out clear directions

to staff and others who provide direct care to resident #001.

Resident # 001 was admitted to the home with several diagnoses.

Resident #001's health care record was reviewed. A progress note made by the Rehabilitation Assistant (RA, #115), on an identified date in May 2017, reflected that the RA #115 had discussion with the resident's Substitute Decision Maker, who had agreed to the use of bolsters and a specified type of sheet on the mattress currently installed on resident #001's bed. RA #115 noted that he would bring up foam bolsters to the unit and inform staff that they would now be used on the mattress.

Resident # 001's plan of care, with an identified date in April 2017, regarding "Risk of Injury from Falls", does include interventions related to the use of fall mats in a specified way, positioning of the bed in a specified way and use of pillows in a specified way. After the assessment completed by RA #115 on the identified date in May 2017, the plan of care was updated on an identified date in June 2017. The updated plan of care included interventions related to the use of bedrails and the use of bolsters in a specified way.

On an identified date in June 2017, RPN #100 called resident #001's family to inform them that the resident had fallen out of his/her bed and did not sustain any apparent injury from the fall.

On June 23, 2017, Personal Support Worker (PSW) #102 explained to Inspector #133 that about a week after a new mattress went into use, on an identified date in May 2017, he had asked RA #115 if a specified type of sheet could be used for resident #001. PSW #S102 indicated that he had explained to the RA that the type of sheet currently in use for resident #001 was "a bit slippery" with the new mattress. PSW #102 explained to the Inspector that he had noticed that resident #001 was sliding "a little bit" downwards in the bed with the type of sheet currently in use. PSW #102 indicated that he had also asked RA #115 if there was something they could use to prevent resident #001 from "going out of the bed", as the PSW had noticed that resident #001 could push himself/herself, with an identified body part, to the side. PSW #102 qualified that resident #001's bed mobility was otherwise very limited. PSW #102 indicated that RA #115 addressed these concerns immediately, and brought up two bolsters and a specified type of sheet.

On June 26, 2017, during an interview, PSW #112 indicated to Inspector #126 that

on the morning of resident #001's fall from bed, on the identified date in June 2017, she was working on resident #001's care unit but was not assigned to resident #001. PSW #112 indicated that she was in the dining room when RPN#124 came and asked for assistance as resident #001 had fallen. She indicated that when she arrived in resident #001's room, she observed resident #001 to be on the floor, lying in a specified way, on the floor mat, that the bed was low and the bed rails up. She indicated that she did not recall seeing any bolsters.

On June 26, 2017, during an interview, PSW #106 indicated to Inspector #126 that he was working the morning of resident #001's fall from bed, on the identified date in June 2017. PSW #106 indicated that he was assigned resident #001. He indicated that prior to the fall, he observed resident #001 in bed, lying in a specified way, and he noticed some redness on a specified area of resident #001's body. After feeding resident #001 his/her breakfast, PSW #106 lowered back the bed, positioned the resident at 45 degrees, put both rails up, and mats were on the floor and positioned the resident with a specified type of pillow. PSW #106, indicated that when he left the room, resident #001 was resting calmly in bed.

On June 27, 2017, during an interview, RPN #100 indicated to Inspector #126 that she administered resident #001's medications on the morning of resident #001's fall from bed, prior to the fall, on the identified date in June 2017. While she was administering the medication, she observed redness on a specified area of resident #001's body, which was the same specified area as had been observed by PSW#106. Resident #001 was observed by RPN #100 to be in bed, lying in a specified way, which was the same specified way as had been observed by PSW#106. RPN #100 observed that resident #001 was sitting up at about 45 degrees, with one half rail up on a specified side of the bed, floor mat on a specified side of the bed, bed was in a low position. When she left the room, RPN #100 indicated that resident #001 was calm and was resting in bed. Approximately thirty to fourty minutes after having administered the medications, RPN #100 heard yelling in the hallway and found resident #001 on the floor in his/her room, lying on the floor in a specified way, which was the same specified way as had been observed by PSW#112, on the floor mat. RPN #100 indicated that she could not recall seeing bolsters on the floor or in the bed.

The licensee has failed to ensure that the written plan of care for resident #001 provided clear directions to staff providing care related to the use of the bolsters and bed rails.

2. The licensee has failed to ensure that the written plan of care for resident #001 provided sets out clear directions to staff and others who provide direct care to resident #001 related to Advance Directives.

Resident # 001 was admitted to the home with several diagnoses.

On an identified date in June 2013, resident # 001 signed a Health Care Directive (HCD) that included direction that the resident's attending physician was to attempt to resuscitate the resident if the resident's heart and lungs fail.

On an identified date in April 2017, resident #001 was sent to hospital for a specified assessment and pain management. Registered Nurse (RN) #103 completed a Do Not Resuscitate (DNR) Form for resident #001 at that time.

On an identified date in June 2017, resident #001 was found on the floor beside his/her bed. As per Registered Practical Nurse (RPN) # 100's progress note, made on the day of resident #001's fall from bed, it was indicated that following the RPN's assessment, the resident was found to have no apparent injuries. Scratches on a specified area of the resident's body were also noted by RPN #100.

On the day of resident #001's fall from bed, in June 2017, resident #001 was to be sent to the hospital for an assessment. RPN #105 prepared the transfer documentation and gave the documents to the family, which included a photocopy of the DNR Form completed by RN #103 on the identified date in April 2017. The family questioned the DNR Form as resident # 001, as per the HCD, expected to be treated aggressively with resuscitation.

On June 23, 2017, during an interview, RPN #105 indicated to Inspector #126 that resident #001 was sent to the hospital on the evening of the identified date in June 2017, after the resident's fall from bed, for an assessment. RPN #105 indicated that she prepared the transfer documentation which included a photocopy of the DNR Form that had been completed by RPN #103 on the identified date in April 2017, which was given to the family. RPN #105 indicated that she was questioned by a family member regarding the DNR Form. She reviewed the health care record and noted that resident #001's HCD directed that resident #001 wished to be resuscitated. RPN #105 indicated that she notified the Program Manager of Resident Care (PMRC) related to the documentation incident related to the DNR

Form.

On June 28, 2017, during an interview, RN #103 indicated to Inspector #126 that she completed a DNR Form on the identified date in April 2017, noting by error that resident #001 did not want to be resuscitated. On the identified date in April 2017, resident #001 was to be sent to the hospital and RPN #103 wanted to assist with the preparation of the transfer documentation. RN #103 indicated that it was expected that residents requiring resuscitation have a white sticker on the side of the binder (heath care record) and when she looked at the binder there was no sticker on resident #001's binder. She assumed it had fallen off the binder. As RPN #103 was preparing the documentation, she reviewed the resident's health care record and noted the physician's "End of Life Care Form" was indicating that resident #001 wish to be resuscitated. However, RPN #103 left the DNR Form on the file and can't explain why she did not destroy the document immediately.

On June 28, 2017, during an interview, the PMRC indicated to Inspector # 126 that RN #122 contacted the Ottawa Hospital to ensure that there was no DNR Form on resident #001's file in the hospital. RN #122 indicated that she talked to Clerical Medical #124 and confirmed that resident # 001 was identified as requiring resuscitation.

The licensee has failed to ensure that the plan of care, related to Advance Directives for resident #001, set out clear directions to staff and others who provided direct care to the resident, between the identified date in April 2017 on which RPN #103 completed the DNR Form and the identified date in June 2017 on which RPN #105 notified the PMRC of the documentation incident related to the DNR Form. [s. 6. (1) (c)]

In this matter, the scope was isolated, however, a Compliance Order is supported due to the potential of risk of harm to resident #001 as the plan of care is not providing clear direction.

The licensee has a history of non-compliance with LTCHA 2007 S.O. 2007, c.8, s.6 (1) (c), one Written notification was issued on September 12, 2017 as a result of inspection 2016_286547_0024.

(126)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Sep 11, 2017

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 27 day of September 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

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Service Area Office / Bureau régional de services : Ottawa