Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 31, Feb 20, 2014	2014_191107_0004	H-000032-14	Resident Quality Inspection

Licensee/Titulaire de permis

BLACKADAR CONTINUING CARE CENTRE INC.
101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7

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

BLACKADAR CONTINUING CARE CENTRE
101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7

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

MICHELLE WARRENER (107), MARILYN TONE (167), VALERIE GOLDRUP (539), YVONNE WALTON (169)

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): January 13, 14, 15, 16, 17, 20, 21, 22, 23, 2014

Referral H-000086-14 was initiated during the Resident Quality Inspection process for the Environmental Health Inspector to follow up on identified maintenance and lighting concerns identified during the RQI inspection and to follow up on outstanding non-compliance with areas related to 2007, c.8, s.5, and regulation 230(4)1&3.

During the course of the inspection, the inspector(s) spoke with Residents and their families, The Administrator, The Acting Director of Care, Nutrition Services Manager/Environmental Manager, Resident Program Manager, Registered Nursing staff, Personal Support Workers (PSW), Dietary Aides, Cooks, Recreation Aides

During the course of the inspection, the inspector(s) toured the home, observed meal service, and care practices, reviewed clinical health records, food production systems, and relevant policies and procedures/protocols

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
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

Findings of Non-Compliance were found during this inspection.

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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system,

or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency. O. Reg. 79/10, s. 9. (1).
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

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

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. Not all doors to the outside of the home were kept closed and locked. On January 15, 2014 at 1137 hours, the gate leading to the parking lot (in the secure outside area) was left unlocked and open which allowed unrestricted and unsupervised access to the parking lot and road. The home had a food delivery the morning of January 15, 2014 and the gate was left ajar. The gate was also left unlatched and unsupervised at 1430 hours January 21, 2014. The gate remained open and unattended by staff, and again residents had unrestricted and unsupervised access to the parking lot and road outside of the home. The Administrator was informed on both occasions. [s. 9. (1)]

2. The door leading to the secure outside area was equipped with a door access control system, however, the door access control system was left on bypass (policy of the home), and the outside area was not supervised by staff while residents were in the secure area. Residents had unrestricted access to the area from the first floor (area accessible to residents of varying abilities) and the area was not supervised by staff. Temperatures during this review were subzero (-32 degress Celsius with the wind chill). During interview, the Administrator stated the home's policy was to leave the area unrestricted (by pass the door access control system) during the day and to activate the door access control system at 2100 hours daily. The area was not routinely supervised and areas at the back of the outdoor secure area were not routinely patrolled by staff. The home's policy was not consistent with required legislative requirements related to supervision of the outdoor area. [s. 9. (1) 1.1.]

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 5]
The licensee did not ensure the home was safe for its residents.
A) On January 13-15, 2014 the lounge/dining area steam tables were turned on 45 minutes to one hour prior to the start of meal service and were left accessible to residents in the lounge/dining areas. The tables were hot to the touch and staff were leaving the area unsupervised for various lengths of time. Interview with the Nutrition Manager on January 15, 2014 confirmed that barriers to restrict access to the hot steam tables outside of meal times were not currently in place. The home was equipped with curtains to surround the steam tables when they were heating up and/or cooling down, however, the curtains were not being used by staff. The Nutrition Manager and dietary staff confirmed they had not used the curtains for a long time. (107)
B) On January 14, 2014 the steam table in one dining area was on and hot while unattended by staff. On January 15, 2014 the dining room was observed again to have the steam table on and hot at 1115 hours, while unattended by staff. The dietary staff confirmed they turned on the steam table at 1110 hours every day to allow it to get hot enough to put lunch food in the steam wells. Nursing staff confirmed they were concerned about resident safety while the steam table was on. (169) [s. 5.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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. [O.Reg. 79/10, s. 15(1)(a)]
The licensee did not ensure that where bed rails were used, the residents were assessed and his or her bed system evaluated in accordance with evidence-based practices, to minimize risk to the residents.
A) The Administrator provided a completed audit of all beds in the home for bedrail entrapment risks. This audit was completed in August 2012 and the Administrator stated deficiencies were identified and corrected in September and November 2012. The Administrator confirmed an audit was not completed after the August 2012 audit to determine if all beds passed the entrapment risk. The Administrator confirmed there was no process in place to track new mattresses as they came into the home to ensure they passed the entrapment risks according to evidence based practices. (169)
B) Resident #101 was noted to be using bed rails when they were in bed.
A review of the health file for the resident indicated that the resident had been using these bed rails since their admission to the home and no assessment of the risks associated with these bed rails was completed. Registered staff interviewed confirmed that no assessment of the bed rail use for the resident was completed for numerous months. (167) [s. 15. (1) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident 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. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 31(1)]
The plan of care for resident #937 did not include the restraining of the resident by a physical device.
A) On several days, resident #937, was noted to be using a restraint in their wheelchair.
B) It was noted that the resident was unable to release the device independently.
C) The document that the home referred to as the care plan, identified as the most current by the Director of Care, did not identify the use of a restraint for the resident when they were in their wheelchair.
D) A review of the physician's orders over a one year period, identified that there was no physician's order for the use of the restraint and this was confirmed by registered staff. [s. 31. (1)]

2. [LTCHA, 2007, S.O. 2007, c.8, s. 31(2)]
The licensee did not ensure that the restraining of residents by a physical device was included in the resident's plan of care only if the expectations set out in s. 31(2) were satisfied.
A) On several days resident #937 was noted to be using a restraint in their wheelchair. It was noted that the resident was unable to release the device independently.
- Personal support worker staff interviewed confirmed that the resident was using a restraint and that the resident was unable to undo it.
- Resident #937 did not have a restraint assessment completed prior to including the restraint in their plan of care that included significant risk to the resident if the resident was not restrained, alternatives to restraint that were considered, tried and found to be ineffective and an assessment indicating the restraint was reasonable in light of the resident's physical and mental condition and was the least restrictive of such reasonable methods. It was confirmed by the Acting Director of Care that the restraint assessments were to be completed in the home's electronic documentation system. Registered staff interviewed confirmed that there was no restraint assessment completed for this resident.
- The document that the home referred to as the care plan, identified as the most current by the Director of Care, did not identify the use of a this restraint for the resident.
- A review of the physician's orders and Three Month Medication Reviews over a one year period for resident #937 revealed that there was no physician's order or order by a registered nurse in the extended class for the restraint that the resident was currently using and registered staff interviewed confirmed that there was no order.
- A review of the resident's health file confirmed that there was no consent obtained for the use of the restraint and the registered staff interviewed confirmed that there was no evidence to support that consent was obtained. (167)
B) On several days, resident #954 was noted to be using a restraint in their wheelchair. The resident was unable to demonstrate their ability to undo the restraint independently.
- Personal support worker staff interviewed confirmed that the resident used the device.
- Resident #954 did not have a restraint assessment completed prior to including the restraint in their plan of care that included significant risk to the resident if the resident was not restrained, alternatives to restraint that were considered, tried and found to be ineffective and an assessment indicating the restraint was reasonable in light of the resident's physical and mental condition and was the least restrictive of such

reasonable methods. It was confirmed by the Acting Director of Care that the restraint assessments were to be completed in the home's electronic documentation system and registered staff interviewed confirmed that there was no restraint assessment completed for the resident.
- The document that the home referred to as the care plan, identified as the most current by the Director of Care, did not identify the use of the restraint for the resident.
- A review of the physician's orders and Three Month Medication Reviews for resident #954 revealed that there was no physician's order or order by a registered nurse in the extended class for the device that the resident was currently using and registered staff interviewed confirmed that there was no order.
- A review of the resident's health file revealed that there was no consent obtained for the use of the restraint and registered staff interviewed confirmed that there was no evidence to support that consent was obtained. (167)
C) The licensee did not ensure the restraint used by resident #941 was included in the plan of care. Resident #941 wore a restraint while up in the wheelchair and they were unable to undo the device independently. The plan of care did not identify the use of the restraint. Staff confirmed the restraint was not included in the plan of care.
- The licensee did not ensure the restraint plan of care for resident #941 included alternatives to restraining that were considered, tried, but had not been effective in addressing the risk. The documentation in the plan of care did not include the alternatives that were tried and the registered nursing staff confirmed this was not completed.
- The licensee did not ensure the restraint plan of care for resident #941 included an order by the physician or the registered nurse in the extended class. The plan of care was reviewed for a one year period and there were no orders to include the use of the restraint. Nursing staff confirmed the lack of an order.
- The licensee did not ensure resident #941 had a restraint plan of care that included the consent by the substitute decision maker. The plan of care was reviewed and the documentation did not include consent for the restraint while up in the wheelchair. Nursing staff confirmed they did not have consent. (169) [s. 31. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 31(1), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 26(3)12]
The plan of care for resident #963 did not include an interdisciplinary assessment of the resident's oral care needs.
A) Resident #963 was noted on observation to have dentures and their own teeth.
B) The document that the home referred to as the care plan for the resident did not include identification of the resident's needs related to oral care.
C) Personal support workers confirmed that the resident had an upper denture and the resident required assistance by staff with oral care twice per day.
D) The Kardex for resident #963 that was available on the care cart, and that staff confirmed was used to direct care, did not include the resident's requirements related to oral care.
E) The document that the home referred to as the care plan did not include an interdisciplinary assessment of the resident's oral and dental status, including the resident's oral hygiene needs.

The plan of care for resident #965 was not based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

A) Resident #965 had some of their own upper and lower teeth.
B) Personal support worker staff confirmed that the resident could brush their own teeth but did require set up by staff to do so. Staff confirmed that the resident received assistance with their oral care in the morning and in the evening. Documentation on the resident care flow records confirmed the resident was receiving assistance with oral care in the morning and in the evening. The resident confirmed this during an interview.
C) During a review of the document that the home referred to as the care plan, it was noted that there was no nursing care plan related to the resident's oral care needs, however a different section of the care plan, indicated that the resident was to receive good oral care before and after meals. Staff interviewed confirmed that the resident required oral care in the morning and the evening only.
D) The plan of care for the resident was not based on an assessment of the resident's oral care needs. [s. 26. (3) 12.]

2. [O.Reg. 79/10, s. 26(3)19]
The licensee did not ensure the plan of care for resident #941 was based on an interdisciplinary assessment with respect to the resident safety risks. On several days, resident #941 was observed wearing a restraint while up in their wheelchair. The resident was unable to undo the device independently as confirmed by the nursing staff. Documentation in the resident's clinical record was reviewed and the Morse Fall assessment identified the resident was moderate risk for falls. The falls risk assessment identified the resident as moderate risk for falls. The physiotherapy assessment was incomplete. The occupational therapist completed a seating assessment for a new wheelchair and did not assess the need for the device on the wheelchair. The resident was observed wearing the restraint while up in the wheelchair and was not able to undo it. The charge nurse confirmed the device was a restraint and there was no assessment completed by any members of the health care team. [s. 26. (3) 19.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the plan of care is based on, at a minimum, interdisciplinary assessment of safety risks, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The Licensee did not ensure that there was a written description of the bowel management program that included its:
- goals and objectives
- relevant policies, procedures, and protocols
- methods to reduce risk
- outcomes monitoring, and
- protocols for referral of residents to specialized resources where required.

A) Two residents and two staff confirmed that resident bowel movements were not consistently documented on the bowel elimination records and laxatives and suppositories were being provided to residents when they did not need to receive them.
B) A review of resident #988's bowel elimination record indicated they had received a laxative after two days rather than the bowel protocol program practice of three days without a bowel movement.
C) The Director of Care confirmed that the bowel protocol practice in the front of the bowel elimination book was the process to be followed including the progressive use of laxatives, suppositories and enema if no bowel movement occurred after three and four days.
D) A member of the registered nursing staff confirmed staff did not document the resident's bowel movement as per the practice of a coloured signature for the different shift. A review of the bowel elimination records for one month confirmed this.
E) The bowel elimination flow sheet protocol at the front of the bowel elimination record book indicated that a member of the registered nursing staff should perform a rectal exam before administering a laxative or suppository. Documentation of this practice was not found.
F) The current bowel protocol practice and bowel elimination records did not contain additional policies or processes to provide clear direction to staff as to their use and documentation. [s. 30. (1)]

2. [O.Reg. 79/10, s. 30(2)]
Actions taken with respect to resident #979 under the Recreation and Social Activities program, including the resident's responses to interventions, were not documented. The quarterly assessment coding for resident #979 was completed, however, a Resident Assessment Protocol (RAP) was not triggered for Recreation and Activities. Documentation did not include an evaluation of the resident in relation to goals and interventions identified on the resident's plan of care. The Recreation Manager and Recreation Aide confirmed that an evaluation was completed, however, was not

documented. Recreation staff confirmed that the evaluation was not documented unless a RAP was triggered. Staff confirmed that the resident had a decline in participation over the quarter resulting to changes in the resident's plan of care. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with regulation 30(1), to be implemented voluntarily.

WN #7: 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. [LTCHA, 2007, S.O. 2007, c.8, s. 33(4)1]
The use of a PASD was included in a resident's plan of care without consideration of alternatives to the use of the PASD.
A) Resident #101 was observed using two bed rails when they were in bed and the document that the home referred to as the care plan indicated the rails were used to assist the resident with positioning while in bed.
B) A review of the resident's health file indicated the resident had been using these bed rails since their admission to the home several months prior and no assessment of the risks associated with these bed rails or alternatives to the use of the bed rails was completed until several months later.
C) Registered staff interviewed confirmed that no assessment of the bed rail use for the resident was completed. [s. 33. (4) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring 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 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. [O.Reg.79/10, s. 71(4)]
Not all planned menu items were offered and available to residents at the breakfast meal January 21, 2014.
A) The planned menu stated a morning glory muffin was to be available and offered to residents on all diet textures. The muffin was not prepared in a pureed texture and not available/offered to residents requiring a pureed texture menu. The Dietary Aide preparing the breakfast meal stated that they were unaware of the need to prepare the muffin in a pureed texture and only provided the pureed toast (both items were identified on the therapeutic extension menu).
B) Resident #102, who required a texture modified menu and received tray service, was not offered the planned menu items (hot cereal, muffin, cottage cheese, banana or toast and eggs). Dietary staff had plated the incorrect texture of meal for the resident, however, this was not identified until the tray was to be served to the resident (0928 hours). All the planned menu items had been discarded in the kitchen from the breakfast meal at that time. Dietary staff stated the resident was offered other foods that were available in the kitchen (bread, yogurt, and fruit).
C) At the lunch meal January 13, 2014, residents requiring a texture modified menu were offered beans, corn and coleslaw, however, the regular texture was offered beans, corn and rice. Dietary staff stated that they had run out of the texture modified rice so coleslaw was substituted. The planned menu was not offered to residents receiving the texture modified texture. [s. 71. (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 with ensuring that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 73(1)6]
Not all food and fluids were served at a temperature that was palatable to residents.
A) At the breakfast meal January 21, 2014, residents receiving tray service had their food plated from the steam table prior to the steam table being cleared and taken down to the dining room (prior to 0900 on the 3rd floor). Food was sitting on the cart (hot cereal and hot beverages were not covered) until staff were ready to deliver the food to residents (0910 3rd floor, 0925 2nd floor). Food temperatures were probed at 114.8 to 129.9 degrees Fahrenheit (F) for the hot cereal and 82.4 degrees F for the egg just prior to service to the residents. Personal support workers (PSWs) did not heat the food prior to service. The PSW delivering the trays stated they were not allowed to use the microwave and would have to take the food back to the kitchen.

The food was not taken down to the kitchen for re-heating. During interview, resident #103, who routinely received tray service, stated their hot food was consistently served cold. Resident's Council also voiced a concern that food on tray service was often cold. The home's policy "Point of Service Food Temperatures DIET-07-01-03 required food to be served at a minimum temperature of 140 degrees F / 60 degrees Celsius (C) and policy DIET-07-01-12 required staff to re-heat foods that do not meet the end point hot holding temperature prior to serving the food.
B) During the lunch meal January 13, 2014, a resident stated their soup was cold. [s. 73. (1) 6.]

2. [O.Reg. 79/10, s. 73(1)8]
The breakfast meal January 21, 2014 was not consistently served course by course. Hot entrees were placed on the table while residents were still consuming their hot cereal. The food in the steam table was cleared out and taken down to the kitchen (Dietary staff stated the food was usually taken down to the kitchen around 0900 hours) so food was plated and placed on the tables for residents prior to taking the cart down to the kitchen. Resident #005 was eating their hot cereal at 0902 hours and their hot entree was placed on the table prior to the completion of their hot cereal. By the time the resident was ready to consume their entree the food was cold. [s. 73. (1) 8.]

3. [O.Reg. 79/10, s. 73(1)9]
Not all residents were provided with the personal assistance and encouragement required to eat and drink as comfortably and independently as possible.
A) At the breakfast meal January 22, 2014, resident #980 sat in-front of their beverages for 15 minutes without assistance provided from staff. The resident's plan of care stated the resident required extensive assistance from 1 staff and much encouragement was needed. The resident was assisted with their entree, however, did not receive assistance and encouragement with their beverages. When the inspector inquired about the resident and staff went to assist the resident with their beverages, they started drinking, however, staff left the resident and they then stopped drinking again. [s. 73. (1) 9.]

4. [O.Reg. 79/10, s. 73(2)(b)]
Residents were served a meal prior to assistance being available at the lunch meal January 13, 2014.
A) Meals were covered and placed on the table for residents #104 and #973. Staff were not available to assist residents at that time.

B) Meals were uncovered and placed on the table for residents #942 and #979 prior to assistance being provided. The residents required total assistance with eating. Staff did not assist resident #979 for at least 15 minutes and the food appeared cold by the time staff were able to assist. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with regulations, sections 73(1)6 and 73(1)9, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 91]

The licensee did not ensure that all hazardous substances were labelled and kept inaccessible to residents at all times. On January 14, 2014 at 1130 hours, a disinfectant was observed under the sink in the second floor dining room. The product was identified by the maintenance manager as disinfectants for the dietary and housekeeping departments. There were a total of three bottles found under the sink, accessible to residents. [s. 91.]

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 with ensuring that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device
Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 110(1)1]
The licensee did not ensure that the restraint being used by resident #954 was applied in accordance with the manufacturer's instructions.
A) On January 16, 2014, the resident's restraint had a gap in excess of three inches between the restraint and the resident. The resident was unable to release the device independently when asked to do so by the inspector.
B) Personal support worker staff confirmed that the gap could be a safety hazard for the resident as they could slip down in the chair.
C) When this was brought to the attention of the personal support worker staff, staff were unable to adjust the device to fit the resident properly.
D) Registered staff staff were made aware of this concern. [s. 110. (1) 1.]

2. [O.Reg. 79/10, s. 110(2)3]
The licensee did not ensure that resident #941 was monitored while restrained at least every hour, by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff. Resident #941 was observed sitting in a wheelchair with a restraint in place from 0900 hours to 1300 hours. The nursing staff did not complete documentation to verify the resident was being monitored while restrained every hour. The nursing staff confirmed they did not document hourly that the resident was being monitored. The plan of care did not include documentation related to hourly monitoring of resident #941. [s. 110. (2) 3.]

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 with regulations, sections 110(1)1 and 110(2)3, to be implemented voluntarily.

WN #12: 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. [LTCHA, 2007, S.O. 2007, c.8, s. 57(2)]
The licensee did not ensure that a response was provided in writing within 10 days of receiving the Residents' Council advice related to concerns or recommendations.
A) The minutes from the Resident Council Meeting documented that formal responses had not been received from the Administration for the months of September, October, November, and December, 2013.
B) An interviewed member of the Resident Council confirmed that the Administration did not always provide a written response within ten days. The minutes were usually posted within five business days but a response was not always immediate and was often responded to in writing in the minutes at the next meeting.
C) The Programs Manager confirmed that a written response had not been provided as noted in the meeting minutes due to the change in the Administrator and the Acting Director of Care. They did confirm that a few of the items had been addressed in writing and other issues were addressed individually with concerned parties. [s. 57. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 87(2)(b)]
The licensee did not ensure the procedures developed for cleaning and disinfection of resident care equipment using hospital grade disinfectant, according to manufacturer's specifications, such as shower chairs, was implemented in the home. On January 13, 2014 at 1400 hours, a reclining shower chair in the tub room was observed with feces on the seat, approximately the size of a quarter. On January 14, 2014 at 1130 hours, the same shower chair was re-inspected and it was noted the same feces spot remained on the chair. A resident had just completed their shower and used the same shower chair which had not been cleaned or sanitized. [s. 87. (2) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 89(1)(a)(i)]
Residents' linens were not changed at least once a week and more often as needed.
A) The licensee did not ensure that resident #963 received a change of bed linen, resulting in the resident laying in a urine soaked bed sheet. The bed of resident #963 was inspected and it was noted the bottom sheet had a strong smell of urine. Upon closer examination, it was noted the mattress cover also was soaked in urine upon touching it. Four hours later the same resident's bed was inspected and the resident was laying in the bed. The bottom sheet was inspected and it was the same sheet as earlier as it had a large urine stain in the middle of it. Two personal support workers were interviewed and they identified the resident had a shower but their bed did not get changed and disinfected as it was supposed to. The two PSW's confirmed the bed linen had not be changed and was soiled.
B) A member of the executive of the Resident's Council was interviewed and confirmed the bed linens were not always consistently changed in the home. [s. 89. (1) (a) (i)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. [O.Reg. 79/10, s. 229(10)3]
The licensee did not ensure that residents were offered immunization against tetanus and diphtheria in accordance with publicly funded immunization schedules.
A) It was noted during a review of the immunization documentation for three identified residents at the home that these residents were not offered immunization against tetanus and diphtheria.
B) The home's policy (02-01-04) Infection Prevention indicated that vaccination for all new residents must be reviewed and the recommendations for vaccination against tetanus and diphtheria was every ten years.
C) During an interview with the Administrator, they confirmed that residents were not currently being offered immunization against tetanus and diphtheria upon admission or at anytime thereafter. [s. 229. (10) 3.]

Issued on this 26th day of February, 2014

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

M Warnener, RD

Ministry of Health and Long-Term Care

Ministére 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

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) :	MICHELLE WARRENER (107), MARILYN TONE (167), VALERIE GOLDRUP (539), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2014_191107_0004
Log No. / Registre no:	H-000032-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 31, Feb 20, 2014
Licensee / Titulaire de permis :	BLACKADAR CONTINUING CARE CENTRE INC. 101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7
LTC Home / Foyer de SLD :	BLACKADAR CONTINUING CARE CENTRE 101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cindy Perrodou

---

To BLACKADAR CONTINUING CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ministry of Health and Long-Term Care

Ministére 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 : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

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.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that:
A) All doors to the outside of the home, including the gate leading to the parking lot, are kept closed and locked.
B) All doors leading to secure outside areas must be equipped with locks to restrict unsupervised access to those areas by residents or ensure supervision of the secure area when the door is un-restricted.
The plan shall be submitted to Long-Term Care Homes Inspector, Michelle Warrener, via e-mail at: Michelle.Warrener@ontario.ca. The plan is to be submitted by March 6, 2014.

Grounds / Motifs :

1. [s. 9.(1)i]
Not all doors to the outside of the home were kept closed and locked. On January 15, 2014 at 1137 hours, the gate leading to the parking lot (in the secure outside area) was left unlocked and open which allowed unrestricted and unsupervised access to the parking lot and road. The home had had a food delivery the morning of January 15, 2014 and the gate was left ajar. The gate was also left unlatched and unsupervised at 1430 hours January 21, 2014. The gate was then left open and unattended by staff, and again residents had unrestricted and unsupervised access to the parking lot and road outside of the home. The Administrator was informed on both occasions. (107)

2. s. 9.(1)1.1]
The door leading to the secure outside area was equipped with a door access control system, however, the door access control system was left on bypass (policy of the home), and the outside area was not supervised by staff while residents were in the secure area. Residents had unrestricted access to the area from the first floor (area accessible to residents of varying abilities) and the area was not supervised by staff. Temperatures during this review were subzero (-32 degress Celsius with the wind chill). During interview, the Administrator stated the home's policy was to leave the area unrestricted (by pass the door access control system) during the day and to activate the door access control system at 2100 hours daily. The area is not routinely supervised and areas at the back of the outdoor secure area are not routinely patrolled by staff. The home's policy was not consistent with required legislative requirements related to supervision of the outdoor area. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2014

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure a safe and secure environment for its residents, including safety with regards to the hot steam tables in the lounge/dining room areas. The plan shall be submitted by March 6, 2014 to Long-Term Care Homes Inspector Michelle Warrener, at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 5]
The licensee has not ensured the home was safe for its residents.
A) On January 13-15, 2014 on the steam tables were turned on 45 minutes to 1 hour prior to the start of meal service and were left accessible to residents in the lounge/dining areas. The tables were hot to the touch and staff were leaving the area unsupervised for various lengths of time. Interview with the Nutrition Manager on January 15, 2014 confirmed that barriers to restrict access to the hot steam tables outside of meal times were not currently in place. The home was equipped with curtains to surround the steam tables when they were heating up and/or cooling down, however, the curtains were not being used by staff. The Nutrition Manager and dietary staff confirmed they had not used the curtains for a long time. (107)
B) On January 14, 2014 the steam table in the dining area was on and hot while unattended by staff. On January 15, 2014 the dining room was observed again to have the steam table on and hot at 1115 hours, while unattended by staff. The dietary staff confirmed they turned on the steam table at 1110 hours every day to allow it to get hot enough to put lunch food in the steam wells. Nursing staff confirmed they were concerned about resident safety while the steam table was on. (169) (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2014

Ministry of Health and Long-Term Care

Ministére 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 : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures that when bed rails are used, residents are assessed and their bed system evaluated in accordance with evidence-based practices, to minimize risk to the residents. The plan shall be submitted by March 6, 2014 to Long-Term Care Homes Inspector Bernadette Susnik at: Bernadette.Susnik@ontario.ca.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 15(1)(a)]
The licensee did not ensure that where bed rails were used, the residents were assessed and his or her bed system evaluated in accordance with evidence-based practices, to minimize risk to the residents.
A) The Administrator provided an audit completed of all beds in the home for bedrail entrapment risks. This audit was completed in August 2012 and the Administrator stated deficiencies were identified and corrected in September and November 2012. The Administrator confirmed an audit was not completed after the August 2012 audit to determine if all beds passed the entrapment risk. The Administrator confirmed there was no process in place to track new mattresses as they came into the home to ensure they passed the entrapment risks according to evidence based practices. (169)
B) Resident #101 was noted to be using bed rails when they were in bed.
A review of the health file for the resident indicated that the resident had been using these bed rails since their admission to the home and no assessment of the risks associated with these bed rails was completed for several months. Registered staff interviewed confirmed that no assessment of the bed rail use for the resident was completed during that time. (167) (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 2014

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 : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident 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.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures the restraining of a resident, including residents #937, #954, and #941 by a physical device is only included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident 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.
6. The plan of care provides for everything required under subsection (3).
The plan shall be submitted electronically by March 6, 2014 to Long-Term Care Home Inspector Michelle Warrener, at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [O.Reg. 79/10, s. 31(2)]
The licensee did not ensure that the restraining of residents by a physical device was included in the resident's plan of care only if the expectations set out in s. 31(2) were satisfied.
A) On several days resident #937 was noted to be using a restraint in their wheelchair. It was noted that the resident was unable to release the device independently.
- Personal support worker staff interviewed confirmed that the resident was using a restraint and that the resident was unable to undo it.
- Resident #937 did not have a restraint assessment completed prior to including the restraint in their plan of care that included significant risk to the resident if the resident was not restrained, alternatives to restraint that were considered, tried and found to be ineffective and an assessment indicating the restraint was reasonable in light of the resident's physical and mental condition and was the least restrictive of such reasonable methods. It was confirmed by the Acting Director of Care that the restraint assessments were to be completed in the

home's electronic documentation system. Registered staff interviewed confirmed that there was no restraint assessment completed for this resident.
- The document that the home referred to as the care plan, identified as the most current by the Director of Care, did not identify the use of a this restraint for the resident.
- A review of the physician's orders and Three Month Medication Reviews over a one year period for resident #937 revealed that there was no physician's order or order by a registered nurse in the extended class for the restraint that the resident was currently using and registered staff interviewed confirmed that there was no order.
- A review of the resident's health file confirmed that there was no consent obtained for the use of the restraint and the registered staff interviewed confirmed that there was no evidence to support that consent was obtained. (167)
B) On several days, resident #954 was noted to be using a restraint in their wheelchair. The resident was unable to demonstrate their ability to undo the restraint independently.
- Personal support worker staff interviewed confirmed that the resident used the device.
- Resident #954 did not have a restraint assessment completed prior to including the restraint in their plan of care that included significant risk to the resident if the resident was not restrained, alternatives to restraint that were considered, tried and found to be ineffective and an assessment indicating the restraint was reasonable in light of the resident's physical and mental condition and was the least restrictive of such reasonable methods. It was confirmed by the Acting Director of Care that the restraint assessments were to be completed in the home's electronic documentation system and registered staff interviewed confirmed that there was no restraint assessment completed for the resident.
- The document that the home referred to as the care plan, identified as the most current by the Director of Care, did not identify the use of the restraint for the resident.
- A review of the physician's orders and Three Month Medication Reviews for resident #954 revealed that there was no physician's order or order by a registered nurse in the extended class for the device that the resident was currently using and registered staff interviewed confirmed that there was no order.
- A review of the resident's health file revealed that there was no consent obtained for the use of the restraint and registered staff interviewed confirmed that there was no evidence to support that consent was obtained. (167)

C) The licensee did not ensure the restraint used by resident #941 was included in the plan of care. Resident #941 wore a restraint while up in the wheelchair and they were unable to undo the device independently. The plan of care did not identify the use of the restraint. Staff confirmed the restraint was not included in the plan of care.
- The licensee did not ensure the restraint plan of care for resident #941 included alternatives to restraining that were considered, tried, but had not been effective in addressing the risk. The documentation in the plan of care did not include the alternatives that were tried and the registered nursing staff confirmed this was not completed.
- The licensee did not ensure the restraint plan of care for resident #941 included an order by the physician or the registered nurse in the extended class. The plan of care was reviewed for a one year period and there were no orders to include the use of the restraint. Nursing staff confirmed the lack of an order.
- The licensee did not ensure resident #941 had a restraint plan of care that included the consent by the substitute decision maker. The plan of care was reviewed and the documentation did not include consent for the restraint while up in the wheelchair. Nursing staff confirmed they did not have consent. (169) [s. 31. (2)] (169)

2. The licensee did not ensure that the following were satisfied prior to including the restraining of resident # 937 by a physical device in their plan of care: a) significant risk to the resident or another person if the resident were not restrained, b) alternatives to restraining have been considered and tried and c) the method of restraining is reasonable, in light of the resident's physical and mental condition and personal history.
A) During a review of the health file the resident, it was noted that there was no restraint assessment was completed for the resident with regards to restraint use prior to including the use of the restraint in their plan of care.
B) It was confirmed by the Acting Director of Care that the restraint assessments are to be completed in the home's electronic documentation system.
C) The registered staff interviewed confirmed that there was no restraint assessment completed for this resident. (167)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2014

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 20th day of February, 2014

Signature of Inspector / Signature de l'inspecteur : M Warrener, RD

Name of Inspector / Nom de l'inspecteur : MICHELLE WARRENER

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