Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 22, 2017	2017_558123_0007	009010-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA
155 PANIN ROAD BURLINGTON ON L7P 5A6

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

CAMA WOODLANDS NURSING HOME
159 PANIN ROAD BURLINGTON ON L7P 5A6

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

MELODY GRAY (123), DIANNE BARSEVICH (581), JESSICA PALADINO (586), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 10, 11, 12, 15, 16, 17, June 12 and August 8, 2017.

The following inspection was completed concurrently with the RQI:
Critical Incident #003858-17 related to an unexpected death and Critical Incident #009451-17 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), registered staff, the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, the Director of Care (DOC) and the Administrator.

During the inspection Inspectors toured the home; reviewed residents' and the home's records including policies and procedures and observed medication administration and infection prevention and control practices.

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

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

16 WN(s)
11 VPC(s)
1 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. 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirement was 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

The identified physical device installation guide and instructions were reviewed and included: When properly adjusted and the physical device tightened, it should fit snug.

A. On two identified days in May, 2017, resident #001 was observed with an identified physical device applied, which was not correctly applied.
The resident's record including the plan of care was reviewed. The plan of care identified the resident required the physical device for safety. The physical device was observed with Personal Support Worker (PSW) #108 on an identified date in May, 2017. PSW #108 was interviewed and confirmed that the physical device was not correctly applied according to the manufacturer's instructions.
The physical device was also observed with PSW #109 on an identified date in May, 2017. PSW #109 was interviewed and confirmed that the resident's physical device was not correctly applied according to manufacturer's instructions and they adjusted it.

B. Resident #006 was observed with an identified physical device applied which was not correctly applied. Review of the plan of care indicated they required the physical device for safety.
Registered staff #103 was interviewed and stated the resident was unable to remove the physical device independently and confirmed it was not applied correctly. They adjusted the physical device to comply with the manufacturer's instructions.

C. On two identified dates in May, 2017, resident #022 was observed with an identified physical device applied that was not applied correctly.
The resident's record including the plan of care was reviewed. The plan of care indicated the resident required the physical device for safety.
Registered staff #110 was interviewed and stated the resident required the physical device for safety. They confirmed that it was not applied correctly according to manufacturer's instructions and adjusted it.
The resident was observed with the physical device applied on an identified date in May, 2017, and it was not applied correctly. PSW #108 was interviewed, confirmed the device was not correctly applied and adjusted it.

D. Resident #020 was observed with an identified physical device applied which was not applied correctly.
The resident's record including the plan of care was reviewed. The plan of care indicated they required the physical device for safety.
The device was observed with registered staff #110. Registered staff #110 was interviewed and stated the physical device was applied for safety. They confirmed the physical device was not applied correctly.

The physical devices were not applied in accordance with manufacturer's instructions. [s. 110. (1) 1.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee failed to ensure that the following was documented: 7. Every release of the device and all repositioning.

On an identified date in May, 2017, resident #020 was observed with an identified physical device applied and at an identified time, they were observed to have the physical device released and to be repositioned.

The resident's record was reviewed including the plan of care and it identified that the resident required the physical device for their safety. Point of Care (POC) documentation for releasing the device and repositioning the resident was reviewed and there was no documentation to indicate that the resident was released and repositioned and as noted above.
The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator was interviewed and stated that the staff were to document hourly safety checks and every two hours on releasing, repositioning and reapplying the physical device. The RAI-MDS Coordinator reviewed the documentation and confirmed the documentation related to releasing of the physical device and repositioning the resident was not completed as required. [s. 110. (7) 7.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: every release of the device and all repositioning, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out, (a) the planned care for the resident.

A. The substitute decision-maker (SDM) of resident #031 was interviewed and indicated that the resident was often restless during an identified period of the day due to having to perform an activity of daily living (ADL); would be assisted with the ADL at specified times, and then would remain up in their mobility device.

The resident's record was reviewed including a specified document, progress notes and care plan. It was noted that the resident would often begin demonstrating a responsive behavior at specified times, would would assisted with an ADL and then remain up in their mobility device.
Registered staff #102 confirmed that the resident would often demonstrate a specific responsive behavior and would require assistance with an ADL and then remain up in their mobility device. They indicated that the resident's SDM requested the specified record be completed nightly so they could review the resident's overnight activities and behaviors. This was also confirmed by the Director of Care (DOC) during interview.

It was noted that on an identified evening in May, 2017, resident #031 was found lying on the floor calling out for help. The following day the resident was sent to the hospital, diagnosed with an identified injury, and received an identified medical intervention.

The resident's SDM was interviewed and indicated that they had requested staff encourage the resident to perform a specific ADL to prevent them from getting up during the night.

The documented plan of care, which front line staff used to direct care identified the resident's preferences and interventions related to ADLs.
The resident's documented plan of care did not include the specific responsive behaviors demonstrated during the night and the interventions required with the identified ADLs.
The written plan of care for resident #031 did not set out the planned care for the resident.

B. Resident #022 was observed sitting in a mobility device, during the course of the inspection.
The record of resident #022 including the plan of care was reviewed. The use of the mobility device was not included in the resident's plan of care.
The DOC was interviewed and confirmed that the resident's plan of care did not set out the planned care for the resident related to the mobility device. [s. 6. (1) (a)]

2. The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #034 was observed during the lunch meal service on an identified date in May, 2017. The resident was observed sleeping at the table with their hands tucked under their clothing protector. Their soup was in front of them for one half hour. Registered staff #103 was observed encouraging the resident to eat their soup during that time. The resident asked for one spoonful which was fed to them, but they were not supported in taking the spoon in their hand. The resident's soup was cleared and they were served an entrée. The resident did not eat any of the food and no staff approached the resident or encouraged them to eat or offered any alternative foods. Approximately ten minutes later, the registered staff removed the resident from the dining room.

The resident's record was reviewed and the plan of care indicated that they needed assistance with eating and were also noted to be at nutritional risk. The plan of care

directed staff to "provide constant encouragement remaining with resident during meals" and to "offer substitutes for uneaten foods".

Resident #034 was not provided with the care set out in their plan of care related to assistance and encouragement with eating. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

A. The record of resident #003 was reviewed including the plan of care. The plan of care indicated that the resident required the use of an identified intervention on their bed.

The resident was observed in bed without the identified intervention in place on an identified date in May, 2017.

PSW #120 was interviewed and could not recall the resident with identified intervention. Registered staff #102 was interviewed and they indicated that they included this entry on the plan of care but that the resident did not like it and it was discontinued; however, the plan of care was not revised to reflect this change.
The plan of care related to the identified intervention for resident #003 was not reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary. 168

B. On an identified date in May, 2017, the bed of resident #031 was observed to have an identified device attached.
The DOC was interviewed and indicated they were not aware of the use of this device, but that the device would not be allowed on any resident's bed due to the high risk of injury and therefore needed to be removed. The DOC later reported that they spoke with the resident's SDM who indicated that they had brought the device in a long time ago which they purchased based on the advice of health care professionals in the community; however, was not aware of the risks and agreed to remove it. The DOC confirmed that the identified device was removed and one of the home's devices was applied.
The resident's record including the plan of care was reviewed and it indicated, the resident did not use the identified device. Spouse brought in and attached the device. The DOC was again interviewed and confirmed the resident's plan of care was not updated to reflect the changes in their use of the identified device.

The home failed to ensure that resident #031's plan of care was reviewed and revised when the resident's care needs changed. 586

C. Resident #006 was observed in a mobility device with an identified device applied. The resident's record including the written plan of care and progress notes was reviewed. The plan of care indicated that the resident was dependent and required a mobility device. Progress notes of an identified date in March, 2017, revealed that the resident was assessed to use the mobility device by the Occupational Therapist.
Registered staff #103 was interviewed and stated resident #006 no longer required the identified device and they confirmed that the plan of care was not reviewed and revised when their care needs changed. 581 [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that: the written plan of care for each resident sets out, the planned care for the resident; the care set out in the plan of care is provided to the resident as specified in the plan and the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

O. Reg. 79/10 s. 114 (2) requires the licensee to ensure that written policies and protocols are developed for the medication management system to ensure the acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's policy and procedure "Administering and Documenting Controlled Substances", #4.3, revised December, 2016, was reviewed. It included: "The quantity of every controlled substance is verified for accuracy at the change of each shift with two registered staff members; shift counts are not to be completed in advance by the outgoing nurse prior to the arrival of the incoming nurse. Each dose of every controlled substance is accounted for on an individual narcotic sheet/record and MAR sheet'.

The individual Narcotic and Controlled Drug Administration and Shift Count Records for multiple residents on an identified home area were reviewed. There were numerous incidences identified where only one staff member signed the above records.
The DOC was interviewed and confirmed that the staff did not follow the home's medication management system policy and procedure as noted above. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices were identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada). The document included: The decision to use, continue to use, or to discontinue the use of a bed rail would be made within the context of an individual resident assessment using an interdisciplinary team with input from the resident or the residents substitute decision-maker (SDM). The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective. Other questions to be considered would be the resident's medical status, behaviors, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether it passed or failed zones one through four). Consideration of these factors would more accurately guide the assessor in making a decision, with either the resident or by the resident's SDM about the necessity and safety of a bed rail. The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

A. Resident #006 was observed in bed with an identified number of bed rails raised. The resident's record was reviewed including the plan of care which identified that the resident needed bed rails raised when in bed to assist with bed mobility and for safety. The plan of care indicated that the bed rails were assessed in January, 2017. The RAI-MDS Coordinator was interviewed and reported that the resident required a fewer number of bed rails raised when in bed to assist them with turning and repositioning and to prevent them from falling out of bed. The RAI-MDS Coordinator confirmed the bed rail risk assessment was not completed when the additional bed rails were raised on the bed and the resident was not assessed for the use of the additional bed rails.

B. The Bed Entrapment audit, dated May, 2016, was reviewed. It noted that only the bed rails at the top of the bed were tested and passed. The home's audit noted if a bed system passed or failed; however, did not include the specific documentation regarding zones one through four. The DOC was interviewed and confirmed that the bed rails at the foot of the bed were not tested when they were applied in January, 2017. The DOC reported that the home had a contracted service provider test the beds once a year and if there were any changes made after this time, before the next scheduled testing, to the bed rails or mattresses, staff would visualize the rails for any gaps or area of concerns and would use their hand to measure the gaps. The DOC stated that "if the gap was bigger than the staff's hand it probably did not pass". The DOC confirmed that the bed rails were not tested for resident entrapment, taking into consideration all potential zones of entrapment at any other time than yearly, with the required weighted equipment to ensure accuracy when testing bed rails.
The home failed to ensure that when bed rails were used, the resident was assessed and their bed system was evaluated to minimize the risk to resident #006.

C. The bed of resident #031 was observed to have an identified device attached.
The Director of Care (DOC) was interviewed and indicated they were not aware of the use of this device, but that the identified device would not be allowed on any resident's bed due to the high risk of injury, and therefore it needed to be removed. The DOC reported that they spoke with the resident's SDM who indicated that they had brought the device in a long time ago on the advice of a health care professional in the community; however, was not aware of the risks and removed it. The DOC confirmed that the device was removed and one of the home's devices was applied.
The resident's record was reviewed and there was no documentation found to indicate that a bed rail assessment was completed after the application of the device.

D. Resident #031's bed was observed to have an identified device attached. The

resident's SDM was interviewed and confirmed this device had been in use for at least several months.
The Bed Rail Risk Assessment dated August, 2016, completed for resident #031 noted the assessment was completed and indicated the bed passed.
The subsequent Bed Rail Risk Assessments dated October, 2016 and April, 2017, included: Bed passed entrapment test conducted in May, 2016. The benefits outweigh the risks, therefore resident will not have bed rails up.
The DOC was interviewed and confirmed that the bed was assessed for entrapment risk in May, 2016, when the resident used bed rails; however, an assessment was not completed when the resident started using a different device in October, 2016. The DOC acknowledged that entrapment zones were not re-assessed for resident #031's bed as above.

The RAI-MDS Coordinator, registered staff #100 and the DOC were interviewed and confirmed that a bed rail assessment should have been completed and the DOC confirmed that this was not done. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The installation and user's instructions for an identified physical device were reviewed.
Resident #008 was observed on two identified dates in May, 2017, with an identified device applied which was not correctly applied.
The resident's record was reviewed. The plan of care identified that they had a physical device applied which they could remove independently.
The resident's device was observed with registered staff #110 on an identified date in May, 2017.
Registered staff #110 was interviewed and they confirmed that the device was not correctly applied according to the manufacturer's instructions and adjusted it. The resident's device was observed with PSW #108 on an identified date in May, 2017. PSW #108 was interviewed and stated the device was not correctly applied and adjusted it.

The device was not applied in accordance with manufacturer's instructions [s. 23.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, 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. A. The licensee failed to ensure that the following was complied with in respect of each of the of the required interdisciplinary programs, that were required under section 48 of the regulation; that the program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and that a written record relating to the evaluation was maintained that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

O. Reg. 79/10 s. 48 (1) requires every licensee of a long-term care home to ensure that they have a falls prevention and management program, to reduce the incidents of falls and the risk of injury.

The home provided a copy of their most recent program evaluation for their falls prevention and management program (which was combined with the restraints program evaluation) dated February, 2017. A review of this evaluation was completed. This evaluation included expectations and goals of the program; however, was not evaluated and updated in accordance with evidence-based practices or prevailing practices. Interview with the DOC confirmed that this "evaluation" was completed by one staff member; that the six bullet points on the one page document was the full program evaluation and did not include a summary of the changes made and the date that those changes were implemented.

B. The licensee failed to ensure that the following was complied with in respect of each of the of the required interdisciplinary programs, that were required under section 48 of the regulation, that the program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and that a written record relating to the evaluation was maintained that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

O. Reg. 79/10 s. 48(1) requires every licensee of a long-term care home to ensure that they have a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The home was requested to produce the written record relating to the 2016 evaluation of the skin and wound care program.
The home's written document, Program Evaluation Skin and or Wound, dated February, 2017, was reviewed and it did not include the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.
The DOC was interviewed and confirmed the above information and also indicated that the evaluation was completed by one identified staff member.

The home's written record of the annual evaluation of the skin and wound care program did not include the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 30. (1)]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

On an identified date in May, 2017, resident #031's bed was observed to have an identified device attached.
The DOC was interviewed and indicated they were not aware of the use of this device, but that the identified device would not be allowed due to the high risk of injury, therefore needed to be removed. Later that day, the DOC reported back that they spoke with the resident's SDM who agreed to remove it, and confirmed that the device was removed and one of the home's devices was applied.
The resident's record and the nursing shift report did not include any documentation about the DOC's conversation with the SDM, the removal of the device or the application of the home's device. [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 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: 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 and the licensee shall keep a written record relating to each evaluation 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

A. Resident #001 was observed with an identified physical device.
The resident's record was reviewed including the plan of care and it was noted that they required the device for safety.
Registered staff #114 was interviewed and stated that the resident required the physical device for safety, there was a physician's order and substitute decision maker (SDM) consent for the device; however, confirmed there was no alternatives to restraining the resident that was considered prior to the resident being restrained with a physical device.

B. Resident #006 was observed with an identified physical device.
The resident's record was reviewed including the plan of care. The plan of care indicated that the physical device was applied on an identified date in April, 2017; however, the Initial Assessment for the Use of Physical Restraint was not completed.
Registered staff #103 was interviewed and reported the Quarterly Review for Use of Physical Restraint was completed on an identified date in April, 2017, but this assessment did not include what alternatives to restraining of the resident were considered and tried to address the risk before restraining resident #006. [s. 30. (1) 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 ensure that no resident of the home is: restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a personal assistance services device (PASD) under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following was satisfied: 1. Alternatives to the use of a PASD had been considered, and tried where appropriate, but would not have been, or have not been, effective to assist the resident with the routine activity of living.

During the course of the inspection, residents #001 and #020 were observed using identified PASDs.
The care plans of residents #001 and #020 were reviewed and both included the use of the PASDs for safety and to prevent falls. No documentation was found in either resident's record to indicate that alternatives to the use of the PASD had been considered.
The DOC was interviewed and reported that the plans of care for both residents included the use of the identified PASDs and that there was no evidence that alternatives to the PASD were considered and tried. [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 to ensure that 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: 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 #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the regulations at the times or at intervals provided for in the regulations.

O. Reg. 79/10 s. 221 (1) 2 identifies that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents: skin and wound care.

O. Reg. 79/10 s. 221 (2) identifies that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act on an annual basis.

A review of the mandatory training records provided by the home for 2016, did not include the training of staff in the area of skin and wound care.
The DOC was interviewed and acknowledged that the training was mandatory, not formally scheduled for 2016 and although some training was completed in 2016, not all staff received the training in skin and wound care.
The DOC verbalized plans to provide the mandatory training to all staff for 2017. [s. 76. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: skin and wound, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.

The home's records related to the analysis of the restraining of residents by use of a physical device for the past six months were reviewed and identified that the home did not complete a monthly analysis in January and February, 2017. The analysis was not fully completed in March, 2017 and in December, 2016.
The DOC was interviewed and confirmed the home did not complete the monthly analysis as identified above. [s. 113. (a)]

2. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

The home's evaluation of the Restraint Release Program was reviewed and it did not include an evaluation to determine the effectiveness of the policy or identify any changes and improvements that were required to minimize restraining.
The DOC was interviewed and confirmed the above. [s. 113. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure, (a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the initial tour of the home, the following was observed:
i. Five containers with unlabeled nail care supplies, which included nail clippers, emery boards and cuticle sticks in an identified spa.
ii. Two containers with unlabeled nail care supplies, which included nail clippers and emery boards which had been used in an identified spa.
iii. Four containers with unlabeled nail supplies, which included nail clippers, emery boards and cuticle sticks in an identified spa room.

PSW #115 and #121 were interviewed and identified that it was the home's expectation that every resident had their own nail care supplies and that the residents' nail care supplies were to be labelled. They confirmed that the nail care supplies in the identified spas should have been labelled. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: Every resident had the right to have his or her personal health information kept confidential in accordance with that Act.

On an identified date in May, 2017, a folder was observed hanging from the Family Information bulletin board that contained documents from the Ministry of Health and Long-Term Care (MOHLTC). The bulletin board was located in an unsecured public area. A copy of the MOHLTC Resident Quality Inspection Licensee Inspection Report dated January, 2017, which contained personal health information of residents was included in the folder for review by staff, visitors and residents.

The Administrator was interviewed and confirmed the licensee report should not have been posted on the bulletin board as it contained residents' personal health information. [s. 3. (1) 11. iv.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that if the Residents' Council had advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee, within 10 days of receiving the advice, responded to the Residents' Council in writing.

Residents' Council meeting minutes were reviewed from January, 2016 to April, 2017. A "Cama Woodlands LTC Home Residents Council Concern Sheet", dated November, 2016, identified concerns relating to meal service and it was suggested that the department supervisor attend the December, 2016, meeting. The concern sheet did not include a response from the supervisor or the Administrator.

Further review of the meeting minutes identified, the December, 2016, meeting was cancelled, and there was no indication that the department supervisor attended the meeting in January, 2017, to discuss the concerns raised at the previous meeting. At the January, 2017, meeting, it was noted that the same concerns from November, 2016, were raised. There was no documentation of a response to that concern and a concern sheet was not completed.

The Administrator was interviewed and indicated that they had not received a copy of the concern form related to the issue raised in November, 2016. The Administrator confirmed that the concerns raised by Residents' Council were not responded to in writing within 10 days of receiving the advice. [s. 57. (2)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations which included copies of inspection reports from the past two years for the long-term care home.

During the course of the inspection it was observed that copies of inspection reports from the past two years for the long-term care home were not posted in the home. A folder hanging from the family information board contained only one Resident Quality Inspection Licensee Report dated January, 2017.
The Administrator was interviewed and confirmed that copies of home's inspection reports from the past two years were not posted in the home. [s. 79. (3) (k)]

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home sought the advice of the Family Council in the development and carrying out of the satisfaction survey.

Interview with the President of Family Council identified that they were an active member of the council for the past two years. The President was not able to recall the home seeking the advice of the Family Council in the development and carrying out the satisfaction survey. Interview with the Administrator confirmed that the satisfaction survey had already been sent out for 2017; however, the home did not seek the advice of the Family Council in the development and carrying out the satisfaction survey. [s. 85. (3)]

2. The licensee failed to ensure that the home sought the advice of the Residents' Council, in developing and carrying out the annual resident and family satisfaction survey, and in acting on its results.

Residents' Council meeting minutes from January, 2016 to April, 2017, were reviewed and there was no documentation to confirm that the home sought the advice of the Residents' Council in developing and carrying out the annual satisfaction survey.

The Administrator was interviewed and acknowledged that the home had used the same questions on the satisfaction survey as the previous year for the purpose of consistency and because of this, had not requested the advice of the Council on the survey questions. They acknowledged that the home did not seek the advice of the Council in developing and carrying out the annual satisfaction survey. [s. 85. (3)]

3. The licensee failed to ensure that the results of the satisfaction survey were documented and made available to the Residents' Council, in order to seek their advice in acting on its results.

The President of the Residents' Council was interviewed and indicated that the Residents' Council was not asked to review the results of the 2016 annual resident and family satisfaction survey.

Resident's Council meeting minutes from January, 2016 to April, 2017, were reviewed and there was no documentation to confirm that the home made the results of the satisfaction survey available to the Council.

The Administrator was interviewed and indicated that a summary of the results of five questions from the satisfaction survey were posted in January, 2017 on the Quality Improvement board located outside of the administration offices; however, could not confirm that the results were shared with the Residents' Council. The Administrator confirmed that there was no documentation that the results of the survey were documented and made available to the Residents' Council in order to seek their advice. [s. 85. (4) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee shall ensure that the resident’s substitute decision-maker (SDM), if any, or any person designated by the SDM and any other person designated by the resident were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who were to be so notified.

The record of resident #031 was reviewed and it noted that on an identified date in May, 2017, they were found lying on the floor calling out for help. The following morning the resident was sent to the hospital. They were diagnosed with an identified injury and an identified medical procedure was performed.
The resident's SDM was interviewed. They voiced concern that they were not notified of the fall until the following morning when the resident was being prepared to be sent to the hospital.
The home's records including the Fall Risk Management Report were reviewed. It was noted that the physician was informed of the fall, but did not include documentation related to notification the resident's SDM.
The DOC and registered staff #124 were interviewed and acknowledged that the resident's SDM was not notified of the injury of the resident. [s. 107. (5)]

Issued on this 7th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELODY GRAY (123), DIANNE BARSEVICH (581), JESSICA PALADINO (586), LISA VINK (168)
Inspection No. / No de l'inspection :	2017_558123_0007
Log No. / No de registre :	009010-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 22, 2017
Licensee / Titulaire de permis :	THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA
LTC Home / Foyer de SLD :	CAMA WOODLANDS NURSING HOME 159 PANIN ROAD, BURLINGTON, ON, L7P-5A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pat Cervoni

To THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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. 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.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The home is to ensure that the following requirement is met with respect to restraining a resident by a physical device under section 31 or section 36 of the Act: All direct care staff are to be educated related to the application of seat belts in accordance with manufacturer's instructions. Monthly audits are to be completed to ensure staff apply the identified physical device in accordance with any manufacturer's instructions when restraining residents, including residents #001, #006, #020 and #022.

Grounds / Motifs :

1. This order is being served based on a severity of two, minimal risk or potential for harm that results in minimal discomfort to the residents and or has potential to negatively affect the resident's ability to achieve his/her potential. Scope of two, pattern, when more than the fewest number of residents are affected and a history of three, previous WN (similar area) with one more related non-compliance in the last three years. A WN was issued in June, 2015, as a result of the Resident Quality Inspection (RQI).

1. The licensee failed to ensure that the following requirement was 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

The identified physical device installation guide and instructions were reviewed and included: When properly adjusted and the physical device tightened, it should fit snug.

A. On two identified days in May, 2017, resident #001 was observed with an identified physical device applied, which was not correctly applied.
The resident's record including the plan of care was reviewed. The plan of care identified the resident required the physical device for safety. The physical device was observed with Personal Support Worker (PSW) #108 on an identified date in May, 2017. PSW #108 was interviewed and confirmed that the physical device was not correctly applied according to the manufacturer's instructions.
The physical device was also observed with PSW #109 on an identified date in May, 2017. PSW #109 was interviewed and confirmed that the resident's physical device was not correctly according to manufacturer's instructions and they adjusted it.

B. Resident #006 was observed with an identified physical device applied which was not correctly applied. Review of the plan of care indicated they required the physical device for safety.
Registered staff #103 was interviewed and stated the resident was unable to remove the physical device independently and confirmed it was not applied correctly. They adjusted the physical device to comply with the manufacturer's instructions.

C. On two identified dates in May, 2017, resident #022 was observed with an identified physical device applied that was not applied correctly.
The resident's record including the plan of care was reviewed. The plan of care indicated the resident required the physical device for safety.
Registered staff #110 was interviewed and stated the resident required the physical device for safety. They confirmed that it was not applied correctly according to manufacturer's instructions and adjusted it.
The resident was observed with the physical device applied on an identified date in May, 2017, and it was not applied correctly. PSW #108 was interviewed, confirmed the device was not correctly applied and adjusted it.

D. Resident #020 was observed with an identified physical device applied which was not applied correctly.

The resident's record including the plan of care was reviewed. The plan of care indicated they required the physical device for safety.
The device was observed with registered staff #110. Registered staff #110 was interviewed and stated the physical device was applied for safety. They confirmed the physical device was not applied correctly.

The physical devices were not applied in accordance with manufacturer's instructions. [s. 110. (1) 1.]

(581)

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 22nd day of August, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : MELODY GRAY

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