Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 16, 2015	2015_391603_0028	018930-15	Resident Quality Inspection

Licensee/Titulaire de permis

FOYER HEARST - MATTICE - SOINS DE SANTE
67-15th Street P.O. Box 1538 HEARST ON P0L 1N0

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

FOYER DES PIONNIERS
67 15TH STREET P.O. BOX 1538 HEARST ON P0L 1N0

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

SYLVIE LAVICTOIRE (603), SARAH CHARETTE (612), TIFFANY BOUCHER (543)

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): August 31-September 4 and September 8-9, 2015

During the course of the inspection, the Inspector(s) reviewed residents' health care records, reviewed various policies, procedures, and programs, conducted a daily walk-through of the home, observed the delivery of resident care, staff to resident interactions, and medication administration. The following Ministry logs were also inspected: #002174-14 and 0024978-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Nursing Staff (RNs, RPNs), Food Service Coordinator, Maintenance Manager, Activity Aid, Housekeeping Staff, Personal Support Workers, Residents, and Family Members.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Snack Observation
Trust Accounts

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

7 WN(s)
5 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide care to resident #015.

Inspector #612 observed the morning medication pass on September 3, 2015. Inspector noted that S#107 crushed the medications for resident #015. Staff #107 stated that there was nothing in resident #015's plan of care that indicated to crush their medications, however S#107 knew to do it as they are familiar with the resident's care requirements.

Inspector spoke with the Director of Care who stated that if a resident requires their medications to be crushed, this would be indicated in the medication administration record (MAR). The Director of Care confirmed that there was nothing in resident #015's plan of care to indicate they required their medications crushed. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #016 as specified in the plan.

On a certain date, Inspector #603 was approached by the home's Director Of Care (DOC) who explained that while resident #016 was eating, they choked on their food and later died in the hospital. The DOC explained that resident #016 was sitting at the dining room table, and in a regular dining room chair for lunch. Resident #017 was sitting with resident #016 and realized that they were choking and called out for assistance from the

attending staff. Staff #103, S#114, S#100, S#115, and S#116 were in the dining room and approached resident #017 and resident #016 as requested. Staff #111 and S#101 reported to the dining room, where S#111 performed the Heimlich Manoeuver until EMS arrived. The resident was then transferred to the hospital where they later died.

Inspector #603 interviewed S#114 over the phone and S#109 was present. Staff #114 said that they had served a specific food to resident #016. Staff #114 explained that resident #016 had requested half portions and did not request to have their food cut, therefore, S#114 did not cut the food for the resident. Staff #114 explained that they knew resident #016 very well and the resident would have asked if they wanted their food cut. Staff #114 also explained that in the past, the resident had never wanted a specific food to be cut. Staff #109 explained that the resident did not have difficulty chewing or swallowing, however, because of their diagnosis, they would at times, ask the staff to cut their food.

Inspector reviewed the unit's 'Dining Room - Choice of foods' and under resident #016's name, it indicated to cut their food. In discussion with S#103, the food that needed to be cut were mainly one type and only when the resident requested it.

Inspector reviewed the resident's heath care record and identified a Dietitian's note, which indicated that the resident did not have difficulty chewing or swallowing foods. The resident had a specific diet. The Dietitian had completed dietary assessments on 5 different occasions. Throughout all subsequent assessments, there were no changes to the resident's diet and texture, nor was there a mention of a difficulty of chewing or swallowing.

Inspector #603 reviewed the resident's care plan which included the following interventions: monitor food intake, cut the foods, open the containers, and assist with setting up only. The resident did not have their food cut up as indicated in the care plan.

LTCHA,007 S.O 2007, s. 6. (7) was issued previously as WN during Inspection #2014_395151_0002. [s. 6. (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 the plan of care set out clear directions to staff and others who provide the care to all residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident was assessed and their bed system evaluated in accordance with evidence-based practices or accordance with prevailing practices to minimize risk to the resident.

On a specific date, Inspector #603 interviewed resident #012 who was sitting in a chair in their room. The resident's bed was made and 2 upper side rails were engaged. Above the bed, there was a paper titled 'Bedside Communication Card' which indicated 2 short siderails needed to be engaged while resident in bed. The resident explained that they use two upper side rails for positioning while in bed and the side rails do not prevent them from sitting on the side or getting out of the bed.

On a certain date, Inspector #603 interviewed S#109, S#110, and S#113 who explained

that the home does not have an ongoing program to assess residents and their bed system. Staff #109 explained that once the resident is assessed for the use of bed rails, there is no evaluation of the resident's bed system to minimize risks to the residents. Staff #109 and S#110 explained that years ago, the home had received special funding to evaluate all bed systems which included the mattress fit and the bed rail mechanism and have not done anymore evaluations of bed systems since then. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On a certain date, Inspector #603 interviewed S#109, S#110, #113 who explained that the home does not have an ongoing program to assess bed rails. Once the resident is assessed for the use of bed rails, there is no step taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

3. The licensee has failed to ensure that where bed rails are used, other safety issues such as height and latch reliability are addressed.

On a certain date, Inspector #603 interviewed S#109, S#110, #113 who explained that the home does not have an ongoing program to assess bed rails. Once the resident is assessed for the use of bed rails, there is no evaluation of the resident's bed system to minimize risks to the resident. The home does not check for bed rail's height and latch reliability.

Staff #109 and S#110 explained that years ago, the home had received special funding to evaluate all bed systems which included the mattress fit and the bed rail mechanism and have not done anymore evaluations of bed systems since then. [s. 15. (1) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.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 every resident has the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On a certain date, Inspector #612 observed S#107 dispose of the emptied medication pouches into the general garbage receptacle on the medication cart. Inspector observed that the medication pouches listed the resident's name and medications that were in that pouch. Staff #107 stated that the home's practice, is to dispose of the garbage from the medication cart in with the regular garbage containers.

Inspector spoke with the Director of Care who confirmed that the home's practice is to dispose of the garbage from the medication pass, including the empty medication pouches, with the regular garbage from the home. [s. 3. (1) 11. iv.]

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 every resident has the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #4: 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 :

The licensee has failed to ensure that the home's Medication Policies were complied with, specifically the Administration of Medication Policy and the Injecting Insulin Policy.

Inspector #612 observed the morning medication pass on a certain date. Inspector noted that S#107 took a syringe out of the medication cart that was filled with a solution and administered it to resident #014. Inspector observed the syringe and noted that there was no resident name or information on the syringe.

Inspector #612 interviewed S#107 who stated that it was a certain medication that was administered to resident #014 as prescribed. Staff #107 showed Inspector #612 that the vial was kept in the fridge and it had a pharmacy label on it. Staff #107 explained that they drew the medication into a syringe from the medication vial, at the beginning of their medication pass, and they stored the filled syringes in the medication cart, until they were ready to administer it. Staff #107 confirmed that the syringes were not labelled with the resident's information.

Inspector #612 interviewed the Director of Care who stated it is the home's expectation that the staff are to draw up medication from the vial in front of the resident prior to administration.

Inspector reviewed the home's policy titled Administration of Medication, code 05-02-03, last reviewed August, 2015. The policy indicated the Registered Staff member prepares the medication for immediate administration. Inspector reviewed the home's policy titled Injecting for a certain medication, code 05-03-07, last reviewed August, 2015. The policy indicated that the registered staff takes the medication vial and new syringe, and prepares the medication in front of the resident, and administers the medication immediately. [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 the home's Medication Policies were complied with, specifically the Administration of Medication Policy and the Injecting Insulin Policy, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

Inspector #612 observed the morning medication pass on a certain date, and noted that S#107 picked up a syringe out of the medication cart that was filled with a solution and administered it to resident #014. Inspector observed the syringe and noted that there was no resident name or information on the syringe.

Inspector #612 spoke with S#107 who stated that it was a certain medication that they administered to resident #014 as prescribed. Staff #107 showed Inspector that the vial was kept in the fridge and it had a pharmacy label. Staff #107 explained that they drew the medication from a vial, into a syringe, at the beginning of their medication pass, and they stored the syringe in the medication cart, until they administer it. Staff #107 confirmed that the syringe was not labelled with the resident's information.

Inspector #612 spoke with the Director of Care who confirmed that it is the home's expectation that drugs remain in the original labelled container or package provided by the pharmacy service provider or Government of Ontario until administered to a resident or destroyed. [s. 126.]

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 drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #612 interviewed S#107 in regards to the home's storage of controlled substances. Staff #107 stated that the controlled substances are stored in a locked box, within the medication cart. Staff #107 confirmed to the Inspector that they do not lock the medication cart because the lock on the medication cart is broken. Staff #107 opened a locked cupboard in the locked medication room and explained that this was where discontinued narcotics were stored until they were destroyed.

Inspector #612 spoke with the Director of Care who stated that the home's expectation is that controlled substances are to be stored in the locked area, within the locked medication cart when it is not in use. [s. 129. (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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area with the locked medication cart, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

On a certain date, Inspector #603 interviewed S#108 who explained that they offered a between-meal beverage to all residents on a specific unit. Staff #108 confirmed that they offered a beverage to residents #001, #003, and #004. At 1055hrs, Inspector interviewed resident #001 and #004 who both explained that they were not offered a between-meal beverage, and resident #003 explained that they were not in their room to be offered a beverage. At 1115hrs, S#108 approached Inspector #603 and explained that they did not in fact, offer a between-meal beverage to resident #001, #003, and #004, because they were rushed and had to complete the morning care. Inspector #603 reviewed the Nutritional Intake Record for resident #001, #003, and #004 and there was no documentation of a between-meal beverage in the morning and afternoon, and a beverage in the evening after dinner, for the month of August and September, 2015.

Inspector #603 interviewed S#109 who explained that the staff are to offer each resident a between-meal beverage in the morning and afternoon, and a beverage in the evening after dinner. Staff #109 explained that the staff should have documented on the Nutritional Intake Record but confirmed that the staff did not document on the record. [s. 71. (3) (b)]

Issued on this 24th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE LAVICTOIRE (603), SARAH CHARETTE (612), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2015_391603_0028
Log No. / Registre no:	018930-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 16, 2015
Licensee / Titulaire de permis :	FOYER HEARST - MATTICE - SOINS DE SANTE 67-15th Street, P.O. Box 1538, HEARST, ON, P0L-1N0
LTC Home / Foyer de SLD :	FOYER DES PIONNIERS 67 15TH STREET, P.O. BOX 1538, HEARST, ON, P0L-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOELLE LACROIX

To FOYER HEARST - MATTICE - SOINS DE SANTE, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. The plan will include the following:
1. A process to ensure that the plan of care for each resident is reviewed, updated, and is provided to the resident as specified in the plan.
2. An auditing process that will serve to identify when staff are not providing care as specified in the plans and a plan for corrective action.
3. A multidisciplinary process to ensure clear communication between RNs, RPNs, and PSWs, so that the care is provided to the resident as specified in the plans.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by November 27, 2015, with full compliance by December 11, 2015.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide care to resident #015.

Inspector #612 observed the morning medication pass on September 3, 2015. Inspector noted that S#107 crushed the medications for resident #015. Staff #107 stated that there was nothing in resident #015's plan of care that indicated to crush their medications, however S#107 knew to do it as they are familiar with the resident's care requirements.

Inspector spoke with the Director of Care who stated that if a resident requires their medications to be crushed, this would be indicated in the medication administration record (MAR). The Director of Care confirmed that there was nothing in resident #015's plan of care to indicate they required their medications crushed. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #016 as specified in the plan.

On a certain date, Inspector #603 was approached by the home's Director Of Care (DOC) who explained that while resident #016 was eating, they choked on their food and later died in the hospital. The DOC explained that resident #016 was sitting at the dining room table, and in a regular dining room chair for lunch. Resident #017 was sitting with resident #016 and realized that they were choking and called out for assistance from the attending staff. Staff #103, S#114, S#100, S#115, and S#116 were in the dining room and approached resident #017 and resident #016 as requested. Staff #111 and S#101 reported to the dining room, where S#111 performed the Heimlich Manoeuver until EMS arrived. The resident was then transferred to the hospital where they later died.

Inspector #603 interviewed S#114 over the phone and S#109 was present. Staff #114 said that they had served a specific food to resident #016. Staff #114 explained that resident #016 had requested half portions and did not request to have their food cut, therefore, S#114 did not cut the food for the resident. Staff #114 explained that they knew resident #016 very well and the resident would have asked if they wanted their food cut. Staff #114 also explained that in the past, the resident had never wanted a specific food to be cut. Staff #109 explained that the resident did not have difficulty chewing or swallowing, however, because of their diagnosis, they would at times, ask the staff to cut their food.

Inspector reviewed the unit's 'Dining Room - Choice of foods' and under resident #016's name, it indicated to cut their food. In discussion with S#103, the food that needed to be cut were mainly one type and only when the resident requested it.

Inspector reviewed the resident's heath care record and identified a Dietitian's note, which indicated that the resident did not have difficulty chewing or

swallowing foods. The resident had a specific diet. The Dietitian had completed dietary assessments on 5 different occasions. Throughout all subsequent assessments, there were no changes to the resident's diet and texture, nor was there a mention of a difficulty of chewing or swallowing.

Inspector #603 reviewed the resident's care plan which included the following interventions: monitor food intake, cut the foods, open the containers, and assist with setting up only. The resident did not have their food cut up as indicated in the care plan.

LTCHA,007 S.O 2007, s. 6. (7) was issued previously as WN during Inspection #2014_395151_0002.

The decision to issue this compliance order was based on the scope and the severity which indicated an actual harm and the compliance history. (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2015

Order # / Ordre no : 002

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

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 develop and implement policies and procedures to 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.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident was assessed and their bed system evaluated in accordance with evidence-based practices or accordance with prevailing practices to minimize risk to the resident.

On a specific date, Inspector #603 interviewed resident #012 who was sitting in a chair in their room. The resident's bed was made and 2 upper side rails were engaged. Above the bed, there was a paper titled 'Bedside Communication Card' which indicated 2 short siderails needed to be engaged while resident in bed. The resident explained that they use two upper side rails for positioning

while in bed and the side rails do not prevent them from sitting on the side or getting out of the bed.

On a certain date, Inspector #603 interviewed S#109, S#110, and S#113 who explained that the home does not have an ongoing program to assess residents and their bed system. Staff #109 explained that once the resident is assessed for the use of bed rails, there is no evaluation of the resident's bed system to minimize risks to the residents. Staff #109 and S#110 explained that years ago, the home had received special funding to evaluate all bed systems which included the mattress fit and the bed rail mechanism and have not done anymore evaluations of bed systems since then. (603)

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On a certain date, Inspector #603 interviewed S#109, S#110, #113 who explained that the home does not have an ongoing program to assess bed rails. Once the resident is assessed for the use of bed rails, there is no step taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. (603)

3. The licensee has failed to ensure that where bed rails are used, other safety issues such as height and latch reliability are addressed.

On a certain date, Inspector #603 interviewed S#109, S#110, #113 who explained that the home does not have an ongoing program to assess bed rails. Once the resident is assessed for the use of bed rails, there is no evaluation of the resident's bed system to minimize risks to the resident. The home does not check for bed rail's height and latch reliability.

Staff #109 and S#110 explained that years ago, the home had received special funding to evaluate all bed systems which included the mattress fit and the bed rail mechanism and have not done anymore evaluations of bed systems since then.

The decision to issue this compliance order was based on the scope which involved all residents who use bed rails and the severity which indicated a potential for actual harm. (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 16th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Lavictoire

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