Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 04, 2019	2019_541169_0015 (A1)	005409-18, 008629-18, 009059-18, 016158-18, 017854-18, 025597-18, 026974-18, 002012-19, 012530-19	Complaint

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
2121 Argentia Road Suite 301 MISSISSAUGA ON L5N 2X4

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

Hardy Terrace
612 Mount Pleasant Road, R.R. #2 BRANTFORD ON N3T 5L5

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

Amended by YVONNE WALTON (169) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

CO #001 compliance due date has been extended to December 31, 2019.

Issued on this 4 th day of November, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Amended by YVONNE WALTON (169) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 17, 18, 19, 20, 21, 24, 25, 26, 27 and July 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 23, 24, 25, 26, 2019.

The following complaints were inspected during this complaint inspection:

Log #012530-19 related to Prevention of Abuse, Skin and Wound Program, Nursing and Personal Support Services-End of Life Care, Nutrition and Hydration Program, Dietary Services and Pain Management Program

Log #026974-18 related to Pain Management, Medication Program, Dining and Snack Service and Prevention of Abuse

Log #016158-18 related to Skin and Wound Program, Incontinence Care, Medication Program

Log #025597-18 related to Medication Program and Prevention of Abuse

Log #017854-18 related to Pest Control Program and Fall Prevention Program

Log #008629-18 related to Responsive Behaviour, Complaints Management Program, Medication Program

Log #002012-19 related to Operation of the Home and Dining and Snack Service

Log #005409-18 related to Skin and Wound Program, Prevention of Abuse and Medication Program

Log #009059-18 related to Pain Management Program, Falls Prevention Program, Dignity Choice and Privacy

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care (DORC), Assistant Director of Resident Care (ADORC), Physiotherapist (PT), Registered Nursing (RN), Registered Practical Nursing

(RPN), Personal support workers (PSW), Dietary Aids (DA), Cooks, Registered Dietitian (RD), Recreation Supervisor, Resident Family Resource Worker, Maintenance Worker, Scheduling/Nursing Clerk, Clinical Resource Nurse, RAI Coordinator, Housekeeping staff, Pharmacist, Medical Director, residents and families.

During the course of the inspection, the inspector(s) observed the provision of care and services throughout the home during the day and evening shift, monitored residents, reviewed records including policies and procedures, meeting minutes, incidents reports and clinical health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Food Quality
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

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

9 WN(s)
7 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	Légende 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. 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 prevailing practices, to minimize risk to the resident.

A) Resident assessments

A companion guide 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) provides the necessary guidance in establishing a clinical assessment where bed rails are used. The guide is cited in a document developed by Health Canada titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008. The Health Canada guide was identified by the Director of the Ministry of Long Term Care in 2012 and 2019, as the prevailing practice with respect to bed safety.

According to the Clinical Guidance document, “in creating a safe bed environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape”. Once an interdisciplinary team has initially assessed a resident for their ability to use bed rails, and deemed them to be beneficial to the resident in their bed mobility activities, residents need to undergo additional monitoring for safety hazards. Residents need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to establish risk-related hazards associated with the

application of one or more bed rails. The risk-related hazards include but are not limited to strangulation, suffocation, bruising or injury against the bed rail, suspension, entanglement and entrapment. The Clinical Guidance document emphasizes the importance of establishing procedures and processes for bed safety monitoring. Monitoring includes but is not limited to who would monitor the residents, for how long and at what frequency, the specific hazards that would need to be monitored for while the resident is in bed with one or more bed rails applied, how to mitigate the specific hazards and what alternatives to bed rails are available and trialled before the application of bed rails.

The Director of Care (DOC) and the Associate Director of Care (ADOC) acknowledged that they did not review the Clinical Guidance document and that corporately, no policies or procedures related to bed safety were developed. Both reported that it was a struggle to convince family members who were involved in the decision making for certain residents with cognitive deficits to replace bed rails with alternatives. The DOC therefore made a decision to leave bed rails on beds with residents who were at higher risk of injury and had the family member sign a consent acknowledging the risks. Discussion was held regarding family education and the development of reading material outlining the regulatory requirements in Ontario regarding the role of the licensee vs the substitute decision makers regarding decisions and processes of resident assessments when bed rails are considered.

Education and training for personal support workers and registered staff was limited with respect to bed safety and associated hazards and strictly included information about why bed rails were used by residents and how. The licensee's form entitled "Bed Rail Assessment" used to document the residents' assessed results, did not include questions related to risk factors for an increased risk of injury associated with bed rail use [i.e. confusion, involuntary movements, sleep disorders, behaviours), conclusions about the resident's sleep habits and behaviours over a period of time, the bed rail alternatives that were trialled (date trialled, what was trialled and whether effective or not), a risk over benefit conclusion or the names of the interdisciplinary team that were involved in the assessment. Although the assessment included some risk related questions (i.e. cognition, medication use, balance and trunk control), the main focus of the assessment was related to why the resident required the bed rails, whether they could use them and the resident's preference.

Three residents assessments were reviewed and did not meet the above

requirements.

B) Bed System Evaluations

Discussion with the maintenance person regarding bed system evaluations revealed that the appropriate cone and cylinder tool were used to measure beds for both gaps and mattress compression as per Health Canada guidelines. A review of the documented results of the evaluations revealed that the bed rails were tested in one locked position only, while in the "guard" or horizontal position. According to the Health Canada guidelines, the bed rails are required to be tested in all locked positions. The bed rail type or model in the home was noted to include a bed rail that could rotate 180 degrees. Two specific locked positions were available for resident use, a guard position for times when the resident is sleeping, and an assist position, for assistance getting in and out of bed. The maintenance person acknowledged that they did not test the bed rails in both locked positions, but recently began testing the bed in both positions, however the forms for recording the results had not been changed to reflect the practice.

The bed systems in the home were not maintained as a unit once the beds were tested for entrapment. Over the last 12 months, the maintenance person tested the beds (mattress and bed rails) and assigned each bed frame an identification number. On the documentation, the mattress was listed by size and style, but not by a unique identifier. The mattress was not labelled to match the frame. As a result, there was no method in which to determine if the same mattress and bed frame that were tested 12 months prior, still had the same mattress on the bed frame. In reviewing the documentation, it was noted that the mattresses had been switched by nursing staff. The maintenance person was not made aware that staff were switching mattresses from one bed to another, which could have created a bed system that no longer passed entrapment testing. The ADOC and DOC were not aware that this practice was occurring. No formal process was in place to notify the ADOC, DOC and maintenance person of any necessary bed system changes and to ensure proper testing and documentation followed.

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 prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails were used that other safety issues related to the use of bed rails were addressed.

According to Health Canada's guidance document, "Adult Hospital Beds: Patient Entrapment Hazards, Side Health Canada Rail Latching Reliability, and Other Hazards" (2008/03/17), mattress movement and compatibility (size, type and thickness) are considered "other hazards". A mattress of the improper type, size, or thickness can lead to enlarged gaps at several zones of entrapment, thus creating potential entrapment hazards. Bed systems that do not include mattress stops or keepers on each corner of the bed increase the potential for mattresses to shift.

During the inspection Long Term Care Homes Inspector #107 observed resident #005's bed and noted the mattress was too short for the bed deck and which slid from side to side and created a large gap between the bed rail and mattress.

A tour of the home and a review of the bed entrapment evaluation results for 2019, revealed that the LTC home was furnished with over 45 bed systems that were purchased more than 15 years prior that included two rotating assist rails per bed. Each bed system passed all four zones of entrapment between July 17, 2018 and July 11, 2019. When evaluated, the mattress was required to be aligned with the deck of the bed and the mattress pushed up against the opposite bed rail. Based on results of the bed evaluations, no other safety concerns were observed or considered.

According to the documentation provided by the maintenance person, a total of 45 bed systems did not have any mattress keepers, only a bottom or top rail. Random beds where checked and the bed mattress was easily pushed or pulled at each corner, creating an alignment issue. The misalignment of the mattress created gaps between the bed rail and the side of the mattress. The gaps were large enough for a resident's head, arm or leg to become trapped between the mattress and the bed rail.

According to the bed manufacturer's user manual, the beds required some assembly by the licensee once delivered. Mattress keepers were included in the assembly instructions. It is not known why all four mattress keepers were not originally installed.

After the safety risks associated with the missing mattress keepers were brought to the attention of the maintenance person on July 15, 2019, Velcro was applied to the deck of some of the beds and to the bottom of the mattresses to keep the

mattress from sliding, as a temporary measure until the bed systems could be replaced.

Issues were also identified whereby staff were swapping mattresses from one bed to another, without ensuring that the length of the mattress was adequate. According to the DOC, new mattresses were ordered to match the length of the bed deck. However, during the inspection, many mattresses were either too short or too long for the deck.

2. Several bed systems included rail models that were overly loose and moved back and forth with very little effort. The stability of the bed rail was insufficient for safe use by residents. The maintenance person was aware of the condition and identified that the bed rails would not remain tight after adjustment. A flaw in the design and type of hardware was suspected. Neither the DOC or maintenance person considered replacing the bed rail type or removing the bed rails and allocating the beds to residents who did not require bed rails.

3. A mattress was observed on a bed frame, which was not properly attached to the bed frame. Straps that were part of the mattress were not secured to the frame of the bed. The mattress was removed by end of day July 18, 2019, after identifying it as a concern with the ADOC.

The licensee failed to ensure that where bed rails were used that other safety issues related to the use of bed rails were addressed. [s. 15. (1) (c)]

3. . [s. 15. (1) (c)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the licensee was required to ensure that the procedure was complied with.

In accordance with O. Reg. 79/10, 90(1)(b), the licensee was required to have in place, procedures and schedules for preventive maintenance.

During the inspection, confirmation was made with both the maintenance person and the Administrator that no formal audits or inspection results were available for review related to the building, including the furnishings, fixtures, surfaces or equipment in 2019 or 2018.

According to the licensee's policies and procedure entitled "Room Inspections – Resident" (ES-VIII-175), "Room Inspections – Common Areas" (ES-VIII-170) and "Preventive Maintenance Program" (ES-VIII-165), developed in 2013, the resident rooms, common areas and certain identified building systems were to be inspected or audited either monthly or annually and to use specific forms to document the results of the audits.

During the inspection, a tour of resident rooms, common areas and the building exterior revealed the following maintenance related issues;

1. Ceiling exhaust fans located in resident washrooms, housekeeping closets, soiled utility rooms and staff washrooms were noisy and when tested using a tissue, limited to no suction was apparent. Exhaust fans were not functional and the exhaust fan in the public washroom near the front entrance was noisy without any suction. The maintenance person reported that some of the exhaust fans were cleaned and/or replaced in March/April 2019, but a record of what was cleaned and/or replaced was not documented. The maintenance person acknowledged that the fans in the two wings were substandard with respect to exhaust efficiency and needed to be replaced to ensure the rate of exhaust was appropriate for the size of the room.

2. Rusty electric baseboard heaters were observed in many resident washrooms.

3. A tub in one wing was identified to have water running from underneath the unit to a floor drain. A sound was also emanating from the tub that resembled running water. According to the maintenance manger, a bladder inside the tub was not tight-fitting and caused water to circulate. A similar repair was made to a tub in another wing the week prior. According to a staff member who used the tub on a daily basis, they were aware of the sound, but did not report the issue. The maintenance person acknowledged that they did not pro-actively check the tubs for function and condition on a scheduled basis and no documentation from the tub manufacturer could be provided to validate that the tubs were inspected for condition as part of their preventive maintenance program.

4. The tub room in a specified wing was observed to have standing pools of water in several locations within the room. The wall with the entry door to the room appeared to have water seepage under the vinyl baseboard along the entire length of the wall. The maintenance person confirmed that other areas of the tub room have had repairs due to water damage, but the entrance wall was not examined to determine if water had penetrated into the wall cavity.

5. The shower enclosure in a specified wingwing tub/shower room was not functional. The shower area was fully blocked with unused equipment. According to the maintenance person, the room was used for storage of floor lifts and other equipment for the last 10 years. Based on discussions with the personal support workers and the ADOC, the shower area would be beneficial for use by independent residents.

6. The downspouts and eaves troughs were noted to be plugged with debris

during heavy rain. One down spout was missing and rain was pouring down onto a walk way. Pools of water were accumulating around the exterior of the building. The maintenance person reported that the roof and water drainage system was required to be cleaned and checked in the spring, but no time was allocated for the work to be conducted.

The licensee failed to ensure that procedures related to preventive maintenance were complied with. [s. 8.]

2. The licensee failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with LTCHA, 2007, S.O. 2007, c.8, s. 11(1) and in reference to O.Reg. 79/10, s. 68(2)(a), the licensee was required to have an organized program of nutrition care, dietary services, and hydration to meet the needs of residents with policies and procedures relating to nutrition care, dietary services and hydration.

Specifically, staff did not comply with the licensee's policy, "Monitoring of Food Temperatures DS-V-004", effective date September 2018. The policy directed staff to check and record final internal cooking temperatures of all foods and to take and record food temperatures prior to meal service for each sitting. The policy also provided direction related to re-heating foods, however, only minimum temperatures were identified and maximum safe temperatures were not included in the policy.

Cooking temperatures were to be recorded in the dining room binders in the servery. Hot holding temperatures were to be taken and recorded in the same book just prior to the meal service for each sitting.

Food Temperature monitoring records were reviewed. The following information was missing from the monitoring records:

Cooking temperatures were not recorded in dining room binders. The holding temperature for the minced hamburger in a dining room was recorded to be 160 degrees Fahrenheit (F). According to the monitoring records, ground meat is required to reach an internal cooking temperature of 162 degrees F for 15 seconds. It is unclear from the monitoring records if this internal temperature was

reached.

Cooking temperatures were not recorded in dining room binders. The temperature monitoring records did not identify what the menu item was for the lunch meal and "Entrée 1" minced texture holding temperatures were recorded at 160 degrees F in the Bell dining room and 160 degrees for the pureed texture in the Grande dining room. It is unclear from the temperature monitoring records if the minimum cooking temperatures were reached.
Cooking temperatures were not recorded for the chicken and veal. Hot holding temperatures were recorded as 163 degrees F for the minced chicken and 155 degrees F for the gravy in a dining room. It is unclear from the monitoring records if minimum cooking temperatures were reached for the chicken. The home's policy required ground poultry to reach a minimum internal cooking temperature of 165 degrees F for 15 seconds. Second sitting temperatures were also not recorded for a dining room.

Cook #129 reviewed the temperature monitoring records with Inspector #107 and confirmed that the identified cooking temperatures were missing and were required to be monitored and recorded. [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 that ensures that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with, specifically, the licensee was required to have an organized program of nutrition care, dietary services, and hydration to meet the needs of residents with policies and procedures relating to nutrition care, dietary services and hydration, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 had their altered skin integrity, including skin tears or wounds, reassessed at least weekly by a member of the registered nursing staff.
Resident #002 demonstrated altered skin integrity and was receiving a treatment cream. There was no documented evidence of a weekly skin assessment completed. This was confirmed by the registered nursing staff, DOC and lack of documentation in the clinical notes.

The licensee failed to ensure that resident #002 received weekly skin assessments for their altered skin integrity issues. [s. 50. (2) (b) (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 that ensures that residents that have altered skin integrity, including skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provided for standardized recipes and production sheets for all menus.

Production sheets, to guide the preparation of all menu items, were not available for staff preparing meals . Cook #107, who prepared meals , confirmed that standardized production sheets, indicating the number of servings of required for each menu item, texture, therapeutic menu, or dining room were not available. The Cook stated that they previously had a form that identified the number of residents requiring each therapeutic menu or texture, however, it had been taken down when the kitchen was painted (four months prior) and it did not include the quantity of each menu item to prepare for each dining area. The Cook stated that they were unclear about the quantity of items to prepare on days that the

Registered Dietitian came to the home as there were changes made to the production numbers for each diet type and texture.

During interview with Inspector #107, the Food Services Manager (FSM) (#106) confirmed that standardized production sheets were not in place and had not been for some time. The FSM stated that a computerized program was not available for the preparation of standardized production sheets and that they would have to implement something manually, which had not been completed at the time of this inspection.

Standardized recipes were not consistently extended to the actual portions required for meals at the long-term care home. Cook #107 confirmed that they prepared approximately 125 servings of soup for residents of the home, however, standardized recipes reflected production numbers of up to 50 portions. The Cook stated that the recipes did not scale properly when you doubled the recipe and adjustments were required to some of the spices or quantities of ingredients. FSM #106 confirmed that the recipes were not extended past 50 portions [s. 72. (2) (c)]

2. The licensee failed to ensure that the food production system provided for documentation on the production sheet of any menu substitutions.

Cook #107 substituted pressed turkey roll for smoked turkey in the salad plate being served to residents. The Cook confirmed the substitution was not recorded and the Food Services Manager also confirmed they had not documented the menu substitution. The visual appeal of the pressed turkey roll was not equivalent to the smoked turkey.

The Food Services Manager (#106) confirmed that there had been some menu substitutions in the menu cycle, however, staff did not currently document or keep a record of any menu or recipe substitutions. [s. 72. (2) (g)]

3. The licensee failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods that preserved taste, nutritive value, appearance, and food quality.

On an identified day, foods were prepared and held at holding temperatures by 1400-1450 hours for the supper meal starting at 1700 hours. The chicken casserole was prepared and held at holding temperatures prior to 1450 hours.

The chicken casserole directed staff to bake the product for 30 minutes and to hold hot food for service for a maximum of two hours. Cook #107 baked the asparagus in the oven prior to 1430 hours for the supper meal. The recipe for asparagus directed staff to use the steamer for 5-7 minutes and to hold hot food for service for a maximum of two hours. Food Committee meeting minutes April 29, 2019, identified that asparagus was being over cooked. The herbed tomato medley recipe was in the oven prior to 1405 hours when the Inspector entered the kitchen. The recipe directed staff to simmer the product for 20 minutes and serve promptly or within two hours or less for the best quality and a maximum of two hours. The potatoes were also hot held at 1450 hours for the supper meal. During interview, Cook #107 stated that the menu was new and that the timing of meal preparation was affected by the limited oven space.

At 1435 hours and the corn kernels for the regular texture meal were finished cooking and hot held for the supper meal. Cook #107 confirmed that the corn was finished cooking and was going into hot holding for the supper meal. FSM #106 confirmed that the vegetables should have been prepared closer to the supper meal service.

At an identified meal service, the texture of the pureed salad plate and pureed tuna sandwich served to residents was very liquid and running over the plates. The recipe for pureed tuna sandwiches stated that pureed foods should hold their shape on a plate. A visual poster in the kitchen also directed staff to prepare pureed foods to a cohesive texture without spreading on a plate. Preparation of pureed texture items to the correct consistency ensures that nutritive value is maintained (not diluted with too much fluid), that food is safe for residents who have difficulty swallowing, and that the food is visually more appealing. During interview with Inspector #107, Cook #107, who prepared the meal, stated that the person serving the meal would check the texture and adjust the food. Cook #108, who served the items, confirmed the pureed items were runny and stated that the person preparing the meal would check the texture.

The nutritive value of fluids offered at snacks was not maintained for residents. During interview with Registered Dietitian #136 and #137 confirmed that the change to diet crystals was not approved by the Registered Dietitian.[s. 72. (3) (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 that ensures that the food production system provided for standardized recipes and production sheets for all menus., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques were used by staff to assist residents with eating at the observed meal.

During an observation of an identified meal, a PSW was observed using the spoon to scrape food off the resident's mouth while they were assisting the resident.

PSW #125 was observed assisting resident #004 with a beverage. The resident was not able to drink as much and as fast as the PSW was pouring and the beverage spilled onto the resident's clothing and/or face with each sip.

The PSW was moving between two tables to assist two different residents with eating. The PSW would put food into resident #003's mouth and then move to the next table for a spoonful for resident #005 and back and forth. Proper feeding techniques were not used to assist resident #003 or #005. Resident #003 also sat for an extended time waiting for staff to resume feeding the resident.
PSW #126 was assisting resident #003 with eating. The PSW used the resident's spoon and cup to scrape food/fluid off the resident's chin after each spoonful. The PSW did not use a napkin to wipe the resident's face until the end of the meal.

During interview with Inspector #107 on July 9, 2019, ADOC #103 confirmed that the techniques used by staff feeding the identified residents were not proper feeding techniques. The ADOC stated the home did not have a policy that directed staff in appropriate feeding techniques. [s. 73. (1) 10.]

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 that ensures ensure that proper techniques were used by staff to assist residents with eating,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).
(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there were sufficient food service workers (FSW) for the home to meet the minimum staffing hours as calculated under subsection (2).

Based on the calculations under subsection (2), the long-term care home was required to have 318.15 FSW hours per week, based on 101 residents. The Administrator of the home confirmed that the home had an occupancy of over 97% during the previous three months.

Food Services Manager (FSM) #106 confirmed that the planned schedule for Food Service Worker hours was 316 hours per week or 632 hours per two week schedule. The planned schedule was two hours short per week of Food Service Worker hours.

The previous three months of staffing schedules were reviewed. The actual scheduled versus on-site Food Service Worker hours provided were:

March 31 – April 13, 2019: 629 scheduled hours (shortage of 7.3 hours per two weeks); 630.47 hours provided (shortage of 5.83 hours per two weeks).
April 14 – 27, 2019: 577.50 scheduled hours (shortage of 58.8 hours per two weeks); 536.04 hours provided (shortage of 110.26 hours per two weeks).
April 28 – May 11, 2019: 561.50 scheduled hours (shortage of 74.8 hours per two weeks); 483.67 hours provided (shortage of 165.52 hours per two weeks).
May 12-25, 2019: compliant with minimum staffing requirements
May 26 – June 8, 2019: scheduled hours 668.50 hours (over minimum by 32.2 hours per two weeks); 628.26 hours provided (shortage of 8 hours per two weeks)
June 9-22, 2019: scheduled hours 640 hours (over minimum requirement by 3.7 hours per two weeks); 490.46 hours provided (shortage of 145.46 hours per two weeks).

During interview with Inspector #107 on July 5, 2019, FSM #106 confirmed that the minimum staffing hours as calculated under subsection (2) were not consistently scheduled or provided over the previous three month period. [s. 77. (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 that ensures that there are sufficient food service workers (FSW) for the home to meet the minimum staffing hours as calculated,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During the inspection, lingering offensive odours were noted in the public washroom near the front entrance. The Administrator was aware of the odour issues. The odour resembled sewage and was the strongest near the floor drain in the washroom. When the drain was checked, no water could be seen inside the drain. A housekeeper was requested to fill the drain with water. The water remained in the drain for a few days, however the odour remained. According to Ministry of Long Term Care inspectors #107 and #169, who were in the home conducting an inspection, strong sewage-like odours were noted, which had spread into the foyer or corridor outside the washroom. The odours lingered for four days, despite interventions taken by the housekeeping staff. Housekeeping staff #132 reported to inspector #169 that they added vinegar to the drain to reduce odours, however it was not always effective. The staff member also reported that they removed the drain cover and cleaned the interior every couple of months with a brush and added vinegar.

According to the maintenance person, via telephone, he was aware of the odour in the public washroom, but no further action was taken once it was determined that pouring water and vinegar into the drains was unsuccessful. Discussion was held regarding the possibility that the drain was not sealed properly or cracked and that a plumber would need to investigate the condition of the drain further.

On July 18, 2019, a sewage-like odour was lingering. The issue was not further investigated by a plumber.

Both the Administrator and DOC acknowledged that there were no procedures available in their library of policies and procedures to address incidents of lingering offensive odours. [s. 87. (2) (d)]

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 that ensures the organized program of housekeeping under clause 15 (1) (a) of the Act, ensures that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received a treatment cream in accordance with the directions for use specified by the physician.

The physician prescribed a treatment cream to be provided to the resident. The treatment cream was administered nine out of the prescribed fourteen times.

The doctor ordered the same treatment as above. The resident received the treatment cream twelve out of the prescribed fourteen times.

Interview with the Director of Care and Assistant Director of Care confirmed the resident did not receive the treatment cream in accordance with the directions for use specified by the physician. [s. 131. (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 that ensures residents receive medications in accordance with the directions for use specified by the prescriber,, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any written complaints that were received concerning the care of a resident or the operation of the home were immediately forwarded to the Director.

A review of the home's complaint log was completed and four written complaints were identified that had been submitted to the Administrator of the home in 2018. The complaints identified concerns related to the operation of the home and resident safety. It was confirmed by the Administrator that these written complaints were not sent to the Director. The Centralized Intake Assessment Triage Team (CIATT) also confirmed they did not receive copies of these complaints.

The licensee failed to forward any written complaints that were received concerning the care of a resident or the operation of the home to the Director. [s. 22. (1)]

Issued on this 4 th day of November, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by YVONNE WALTON (169) - (A1)
Inspection No. / No de l'inspection :	2019_541169_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005409-18, 008629-18, 009059-18, 016158-18, 017854-18, 025597-18, 026974-18, 002012-19, 012530-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 04, 2019(A1)
Licensee / Titulaire de permis :	Diversicare Canada Management Services Co., Inc. 2121 Argentia Road, Suite 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	Hardy Terrace 612 Mount Pleasant Road, R.R. #2, BRANTFORD, ON, N3T-5L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deborah Langlois

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Diversicare Canada Management Services Co., Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (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 be compliant with s.15(1)(a) and (c) of O. Reg. 79/10.

Specifically, the licensee shall complete the following;

1. Amend the home's existing "Bed Rail Assessment " form to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003). This document is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards ". The amended questionnaire shall, at a minimum, include:
a) questions that can be answered by the assessors related to the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to and after the application of any bed rails; and
b) the alternatives that were trialled prior to the application of one or more bed rails and document whether the alternatives were effective during the

specified period of use or if no alternatives were trialled, document why they were not trialled; and
c) include the names of the interdisciplinary team members who participated in assessing the resident.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed rail assessment form and document the assessed results and recommendations for each resident.

3. Update the written plan of care for those residents where changes were identified after assessing each resident using the amended bed rail assessment form. Include in the written plan of care what position the bed rails are to be applied in, how many bed rails are to be applied and on what side. If any accessories or interventions (i.e. rail pads, bolsters) are required to mitigate any safety risks, the specific accessory and use instructions are to be included.

4. Obtain or develop written material that can be made available for families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, how beds are determined to pass or fail entrapment zone testing, the role of the Substitute Decision Maker and the licensee with respect to resident assessments and any other relevant facts associated with bed systems and the use of bed rails.

5. Develop procedures that encompasses resident assessments and bed system evaluations. The procedures shall include but not be limited to the following guidance:

a) PSW role in monitoring residents while in bed with bed rails applied and the safety risks that need to be monitored for; and
b) Registered staff role in assessing residents where bed rails have been requested or indicated for use; and
c) Substitute Decision Maker's role in making decisions about the application of bed rails; and
d) Maintenance staff role in ensuring that the bed systems are evaluated as per Health Canada guidelines; and

e) The role of any other selected interdisciplinary members involved in the resident assessments; and
f) The available alternatives to bed rails and the accessories that are available to mitigate any identified risks or hazards; and
g) The process for recognizing and reporting bed system deficiencies; and
h) The process for reporting bed system changes to management staff (i.e. mattress exchanges); and
i) Guidance for the assessors in being able to make clear decisions based on the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
j) The name of the documents and references used to develop the policy.

6. Registered staff who complete the bed rail risk assessments shall have knowledge of the contents of the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) and the "Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, (U.S. F.D.A, 2006)".

7. All registered and non-registered staff shall be informed about the bed safety procedures and be provided with face to face education about bed system hazards (zones of entrapment and other injuries), regulatory requirements in Ontario regarding adult hospital beds, the risks and benefits of bed rail use, resident risk factors associated with increased risk of injury related to bed rail use, how to identify and report bed system deficiencies and any other relevant information identified in the prevailing practices.

8. All bed systems shall be re-evaluated using the methods and processes described in the Health Canada guidelines and each bed frame and mattress is to be labelled with the same identifier. The results of the evaluation shall be documented.

9. Each bed system where bed rails are in use, whether in the guard or assist position, shall be modified so that the mattress does not slide side to side or move about on the deck of the bed.

10. All bed systems that are equipped with rotating assist rails that are loose and unstable and cannot be tightened or adjusted, shall be removed from the bed frame.

Grounds / Motifs :

1. 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 prevailing practices, to minimize risk to the resident.

A) Resident assessments

A companion guide 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) provides the necessary guidance in establishing a clinical assessment where bed rails are used. The guide is cited in a document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008. The Health Canada guide was identified by the Director of the Ministry of Long Term Care in 2012 and 2019, as the prevailing practice with respect to bed safety.

According to the Clinical Guidance document, "in creating a safe bed environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape". Once an interdisciplinary team has initially assessed a resident for their ability to use bed rails, and deemed them to be beneficial to the resident in their bed mobility activities, residents need to undergo additional monitoring for safety hazards. Residents need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to establish risk-related hazards associated with the application of one or more bed rails. The risk-related hazards include but are not limited to strangulation, suffocation, bruising or injury against the bed rail, suspension, entanglement and entrapment. The Clinical Guidance document emphasizes the importance of establishing procedures and processes for bed safety monitoring. Monitoring includes but is not limited to who would monitor the residents, for how long and at what frequency, the specific hazards that would need to be monitored for while the resident is in bed with one or more bed rails applied, how to mitigate the specific hazards and what alternatives to bed rails are available and trialled before the application of bed rails.

The Director of Care (DOC) and the Associate Director of Care (ADOC) acknowledged that they did not review the Clinical Guidance document and that corporately, no policies or procedures related to bed safety were developed. Both reported that it was a struggle to convince family members who were involved in the decision making for certain residents with cognitive deficits to replace bed rails with alternatives. The DOC therefore made a decision to leave bed rails on beds with residents who were at higher risk of injury and had the family member sign a consent acknowledging the risks. Discussion was held regarding family education and the development of reading material outlining the regulatory requirements in Ontario regarding the role of the licensee vs the substitute decision makers regarding decisions and processes of resident assessments when bed rails are considered.

Education and training for personal support workers and registered staff was limited with respect to bed safety and associated hazards and strictly included information about why bed rails were used by residents and how. The licensee's form entitled "Bed Rail Assessment" used to document the residents' assessed results, did not include questions related to risk factors for an increased risk of injury associated with bed rail use [i.e. confusion, involuntary movements, sleep disorders, behaviours), conclusions about the resident's sleep habits and behaviours over a period of time, the bed rail alternatives that were trialled (date trialled, what was trialled and whether effective or not), a risk over benefit conclusion or the names of the interdisciplinary team that were involved in the assessment. Although the assessment included some risk related questions (i.e. cognition, medication use, balance and trunk control), the main focus of the assessment was related to why the resident required the bed rails, whether they could use them and the resident's preference.

Three residents assessments were reviewed and did not meet the above requirements.

B) Bed System Evaluations

Discussion with the maintenance person regarding bed system evaluations revealed that the appropriate cone and cylinder tool were used to measure beds for both gaps and mattress compression as per Health Canada guidelines. A review of the documented results of the evaluations revealed that the bed rails were tested in one locked position only, while in the "guard" or horizontal position. According to the Health Canada guidelines, the bed rails are required to be tested in all locked

positions. The bed rail type or model in the home was noted to include a bed rail that could rotate 180 degrees. Two specific locked positions were available for resident use, a guard position for times when the resident is sleeping, and an assist position, for assistance getting in and out of bed. The maintenance person acknowledged that they did not test the bed rails in both locked positions, but recently began testing the bed in both positions, however the forms for recording the results had not been changed to reflect the practice.

The bed systems in the home were not maintained as a unit once the beds were tested for entrapment. Over the last 12 months, the maintenance person tested the beds (mattress and bed rails) and assigned each bed frame an identification number. On the documentation, the mattress was listed by size and style, but not by a unique identifier. The mattress was not labelled to match the frame. As a result, there was no method in which to determine if the same mattress and bed frame that were tested 12 months prior, still had the same mattress on the bed frame. In reviewing the documentation, it was noted that the mattresses had been switched by nursing staff. The maintenance person was not made aware that staff were switching mattresses from one bed to another, which could have created a bed system that no longer passed entrapment testing. The ADOC and DOC were not aware that this practice was occurring. No formal process was in place to notify the ADOC, DOC and maintenance person of any necessary bed system changes and to ensure proper testing and documentation followed.

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 prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)] (120)

2. The licensee failed to ensure that where bed rails were used that other safety issues related to the use of bed rails were addressed.

According to Health Canada's guidance document, "Adult Hospital Beds: Patient Entrapment Hazards, Side Health Canada Rail Latching Reliability, and Other Hazards" (2008/03/17), mattress movement and compatibility (size, type and thickness) are considered "other hazards". A mattress of the improper type, size, or thickness can lead to enlarged gaps at several zones of entrapment, thus creating potential entrapment hazards. Bed systems that do not include mattress stops or keepers on each corner of the bed increase the potential for mattresses to shift.

During the inspection Long Term Care Homes Inspector #107 observed resident #005's bed and noted the mattress was too short for the bed deck and which slid from side to side and created a large gap between the bed rail and mattress.

A tour of the home and a review of the bed entrapment evaluation results for 2019, revealed that the LTC home was furnished with over 45 bed systems that were purchased more than 15 years prior that included two rotating assist rails per bed. Each bed system passed all four zones of entrapment between July 17, 2018 and July 11, 2019. When evaluated, the mattress was required to be aligned with the deck of the bed and the mattress pushed up against the opposite bed rail. Based on results of the bed evaluations, no other safety concerns were observed or considered.

According to the documentation provided by the maintenance person, a total of 45 bed systems did not have any mattress keepers, only a bottom or top rail. Random beds where checked and the bed mattress was easily pushed or pulled at each corner, creating an alignment issue. The misalignment of the mattress created gaps between the bed rail and the side of the mattress. The gaps were large enough for a resident's head, arm or leg to become trapped between the mattress and the bed rail.

According to the bed manufacturer's user manual, the beds required some assembly by the licensee once delivered. Mattress keepers were included in the assembly instructions. It is not known why all four mattress keepers were not originally installed.

After the safety risks associated with the missing mattress keepers were brought to the attention of the maintenance person on July 15, 2019, Velcro was applied to the deck of some of the beds and to the bottom of the mattresses to keep the mattress from sliding, as a temporary measure until the bed systems could be replaced.

Issues were also identified whereby staff were swapping mattresses from one bed to another, without ensuring that the length of the mattress was adequate. According to the DOC, new mattresses were ordered to match the length of the bed deck. However, during the inspection, many mattresses were either too short or too long for the deck.

2. Several bed systems included rail models that were overly loose and moved back and forth with very little effort. The stability of the bed rail was insufficient for safe use by residents. The maintenance person was aware of the condition and identified that the bed rails would not remain tight after adjustment. A flaw in the design and type of hardware was suspected. Neither the DOC or maintenance person considered replacing the bed rail type or removing the bed rails and allocating the beds to residents who did not require bed rails.

3. A mattress was observed on a bed frame, which was not properly attached to the bed frame. Straps that were part of the mattress were not secured to the frame of the bed. The mattress was removed by end of day July 18, 2019, after identifying it as a concern with the ADOC.

The licensee failed to ensure that where bed rails were used that other safety issues related to the use of bed rails were addressed. [s. 15. (1) (c)]

3. . [s. 15. (1) (c)] (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2019(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 4 th day of November, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by YVONNE WALTON (169) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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