Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

**Division des foyers de soins de longue durée**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 13, Dec 21, 2016 | 2016_283542_0005 | 022124-16 | Resident Quality Inspection |

### Licensee/Titulaire de permis

LADY DUNN HEALTH CENTRE
17 Government Road Box 179 Wawa ON P0S 1K0

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

LADY DUNN HEALTH CENTRE
17 Government Road P.O. Box 179 Wawa ON P0S 1K0

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

JENNIFER LAURICELLA (542), SYLVIE BYRNES (627)

### 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): October 3-7, 2016 and October 11-14, 2016.**

**A Follow-up intake, for five Compliance Orders (CO) were also completed during this inspection. The CO's were in regards to the following: CO #001 related to s. 221 (2) regarding training to all direct care staff, CO #002 and CO #003 related to s. 110 (1) and (7) regarding application of restraints and restraint documentation, CO#004 related to s. 15 (1) regarding bed rails and CO #005 related to s. 6 (1) regarding written plan of care.**

**During the course of the inspection, the inspector(s) spoke with the Director of Patient Care (DOPC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Staff, Recreational Staff, Dietary Staff, Residents and family members.**

**During the course of the inspection, the Inspectors completed numerous observations of the provision of care and services to residents, reviewed resident health care records, employee files and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**

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

**11 WN(s)**
**8 VPC(s)**
**4 CO(s)**
**0 DR(s)**
**0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 110. (1) | CO #002 | 2015_332575_0020 | 542 |
| O.Reg 79/10 s. 110. (7) | CO #003 | 2015_332575_0020 | 542 |
| O.Reg 79/10 s. 15. (1) | CO #901 | 2016_283542_0005 | 542 |
| O.Reg 79/10 s. 221. (2) | CO #001 | 2015_332575_0020 | 542 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During this Resident Quality Inspection (RQI), on October 4, 2016, Inspector #542 and Inspector #627 observed resident #002, #003, #004, #006, #007 and #008 to have their bed rails raised. On October 6, 2016, Inspector #542 observed all of the above bed rails to have a large gap within them.

Inspector #542 spoke with the RPN Team Lead (TL) #102 who indicated that the maintenance staff had just begun changing the bed rails as a result of last year's inspection and that they were waiting for parts. The TL also said that they did not believe that any other staff member was evaluating the bed systems.

Inspector #542 spoke with maintenance staff #103 and #104. Both staff members said that all of the bed system assessments were conducted in June 2016, as a result of the last RQI inspection in 2015. They also indicated that all of the beds had failed the inspections due to the bed rails and the entrapment zones. They provided the inspector with the documentation regarding the bed system assessments. Inspector #542 reviewed the documentation that was provided which was dated June 1-4, 2016. The documentation supported that 16 out of 16 beds failed zone 1 and that 14 out of 16 beds failed zone 3 of the entrapment testing. All fails were due to the bed rail designs.

According to the document all of the above mentioned resident bed systems failed both zones 1 and 3.

Inspector #542 spoke with the Director of Patient Care (DOPC) who is the home's Administrator and Director of Care. They informed the Inspector that all of the bed systems failed the zone entrapment testing that was completed by the maintenance staff in the summer, however they are waiting for the parts in order to change the bed rails. Inspector asked if the home was doing anything in the meantime to ensure resident safety when the bed rails are being used. The DOPC did not answer the question. Inspector #542 informed her that numerous observations were made in which large gaps on the bed rails themselves were noted. Inspector #542 asked if the home had developed some kind of a plan to ensure that the resident's that were at a potential risk for injury had their bed rails changed first. The DOPC said that they had not come up with any type of a plan but they would do so now.

On October 6, 2016, Inspector #542 met with the Director of Patient Care (DOPC). The inspector asked the DOPC if the licensee assessed the residents when bed rails where being used. They indicated that they were not aware that they were required to do this and felt that the overall assessment of the bed system was enough.

On October 6, 2016, Inspector #542 observed the maintenance staff to be changing a resident's bed system that consisted of different bed rails that contained a large gap between the two rails.

On October 11, 2016, Inspector #627 and #542 were approached by a resident's family member. They expressed their concern that the home changed the resident`s bed system.  After the bed system was changed, the resident suffered a fall from their bed.

Inspector #542 reviewed the resident's health care record. It was documented on the care plan that the resident was at a risk for falls prior to them falling out of bed after their bed system was changed.

Inspector #542 spoke with the DOPC and asked if an assessment was completed for the resident regarding their bed system and the use of the bed rails. The DOPC indicated that no assessment was completed even after the change of the bed system.

Despite the licensee being aware that all bed systems failed at least one zone of entrapment, they continued to use the bed rails and failed to put anything in place to

prevent resident entrapment. The licensee also failed to ensure that when bed rails are used, residents are assessed with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1)]

***Additional Required Actions:***

***CO # - 901 was served on the licensee. CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents of the home were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

Under O.Reg 79/10, neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Inspector #542 completed a health care record review for resident #006. The current care plan identified that resident #006 required assistance with meals and that the nursing staff were to monitor their intake at all meals and snacks. It was also noted that the Registered Dietitian (RD) documented that resident #006 was at a nutritional risk.

On October 13, 2016 at approximately 1000 hours (hrs), Inspector #542 observed resident #006 in their night clothes, in bed sleeping.

On October 13, 2016 during an interview, Inspector #542 asked RPN #117 why resident #006 remained in bed in their night clothes. They said that it was easier to leave them in

bed on their shower day. Inspector #542 then asked if resident #006 had received breakfast. The RPN #117 stated, no but they could give them something, however it was too close to lunch.

Inspector #542 reported the incident to the Director of Patient Care (DOPC) at approximately 1030 hours informing them that resident #006 had not been provided with breakfast. The DOPC said that it was an expectation that staff offer all residents their meals and that this was neglect as they failed to offer resident #006 breakfast.

2. Compliance Order #001 was issued during inspection # 2015_332575_0020. The licensee was to complete the following by February 29, 2016: 1) Conduct bed system assessments for all residents who require the use of bed rails, following the Health Canada guidance document; 2) Train staff on the use of the bed rails and bed system, specifically, zones of entrapment; 3) Maintain a record of the resident assessment and bed system assessment, including the type of mattresses and beds used for each resident; 4) Ensure steps are taken to prevent resident entrapment where dimensional limits exceed the recommended limits.

Under O.Reg 79/10, neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents." The home has shown a pattern of inaction that jeopardizes the health, safety and well-being of one or more residents by failing to address the risk of entrapment. An immediate compliance order was issued during this inspection as the home failed to complete a resident assessment and that their bed system was evaluated before and after the change of the bed rails which resulted in the resident falling out of their bed (see WN # 1 for further details).

On October 4, 2016, Inspector #542 and Inspector #627 observed resident #002, #003, #004, #006, #007 and #008 to have their bed rails in the guard position. On October 6, 2016, Inspector #542 observed all of the above bed rails to have a large gap within them.

On October 5, 2016 at 1624 hours, during an interview with Inspector #542, the RPN Team Lead (TL) #102 indicated that the maintenance staff had just begun changing the bed rails as a result of last year's inspection and that they were waiting for parts. The TL also said that they did not believe that any other staff member was evaluating the bed systems.

Inspector #542 interviewed maintenance staff #103 and #104. Both staff members said that all of the bed system assessments were conducted in June 2016, as a result of the last Resident Quality Inspection (RQI) in 2015. They also indicated that all of the beds had failed the inspections due to the bed rails and the entrapment zones. They provided the Inspector with the documentation regarding the bed system assessments.

Inspector #542 reviewed the documentation that was provided which was dated June 1-4, 2016. The documentation supported that 16 out of 16 beds failed zone 1 and that 14 out of 16 beds failed zone 3 of the entrapment testing. All fails were due to the bed rail designs. According to the document all of the above mentioned resident bed systems failed both zones 1 and 3.

On October 6, 2016, Inspector #542 interviewed the Director of Patient Care (DOPC) who was the home's Administrator and Director of Care. They informed the Inspector that all of the bed systems failed the zone entrapment testing that was completed by the maintenance staff in June 2016, however they were waiting for the parts in order to change the bed rails. The Inspector asked what the home was doing to ensure resident safety when the bed rails are being used. The DOPC did not answer the question. Inspector #542 informed the DOPC that numerous observations were made in which large gaps on the bed rails themselves were noted. Inspector #542 asked if the home had developed a plan to ensure that the residents that were at a potential risk for injury had their bed rails changed first. The DOPC said that they did not have a plan. The DOPC also indicated that they were not aware that they were required to assess the residents when bed rails where being used and felt that the overall assessment of the bed system was adequate.

On October 6, 2016, Inspector #542 observed the maintenance staff to be changing a resident's bed system that consisted of different bed rails that contained a large gap between the two rails.

On October 11, 2016, Inspector #627 and #542 were approached by a resident's family member. They expressed their concern that the home changed the resident's bed system. After the bed system was changed, the resident suffered a fall from their bed.

Inspector #542 reviewed the resident's health care record. It was documented on the care plan that the resident was at a risk for falls prior to them falling out of bed after their bed system was changed.

Inspector #542 spoke with the DOPC and asked if an assessment was completed for the resident regarding their bed system and the use of the bed rails. The DOPC indicated that no assessment was completed before or after the change of the bed system.

Previous non-compliance was identified in November 2014 during inspection #2014_339579_0013 where a Voluntary Plan of Correction (VPC) was issued as the licensee failed to take steps to prevent resident entrapment. In December 2015, during inspection #2015_332575_0020 a Compliance Order (CO) was issued with regards to the bed systems and resident assessments when bed rails were being used. The inspection revealed that despite a previous non-compliance the home continued to fail completing any bed system assessments when bed rails where being used. It was also determined that the home was using full bed rails that consisted of large gaps within them. These gaps exceeded the measurements that are set out in the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latch Reliability, and Other Hazards.'

Despite the licensee being aware that all bed systems failed at least one zone of entrapment, they continued to use the bed rails and failed to take steps to prevent resident entrapment. The licensee also failed to ensure that when bed rails were used, residents were assessed with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

3. During stage one of the RQI, resident #002 and their family member informed Inspector #627 that a PSW had been rough while providing care to them. The resident had tears in their eyes while the PSW was performing their care. Furthermore, the resident stated to the family member that the PSW did not fully assist them with specific care. The family member and the resident were unable to identify the date of those occurrences but stated it had occurred "not long ago". The family member had reported both incidents to RPN #115.

A health care record review was completed by Inspector #627 for resident #002. The care plan included specific interventions for staff to use when providing care. The care plan also revealed that resident #002 required one staff to provide assistance with specific care.

A review of the home's investigation notes provided to Inspector #627 by RPN #102 and the DOPC revealed that PSW #106 was removed from resident #002's assignment list

and that they received disciplinary action.

During an interview on October 11, 2016, with the Inspector, RPN #115 stated that they became aware of the incident on a specific day and reported it to the DOPC on that same day.

During an interview on October 11, 2016, with the Inspector, the DOPC stated that they were made aware of the incident, by RPN #115 but started their investigation the following day. The DOPC also indicated that they did not report the alleged abuse to the Director.

Non Compliance (NC) related to this finding was also issued under Written Notification (WN) #6 and #7.

4. Under O.Reg 79/10, neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

During stage one of the RQI, resident #001, #002 and #003 were identified as frequently incontinent of urine by the Resident Assessment Instrument-Minimum Data Set (RAI-MDS).

A review by Inspector #627 of the form titled, "Appendix A: Bladder and Bowel Continence Assessment" for resident #001, #002 and #003, identified causal factors, patterns and types of incontinence, however it did not contain any potential to restore function with specific interventions for any of the residents.

Inspector #627 reviewed resident #001, #002 and #003's care plan which revealed that all of the residents required some sort of assistance for continence care from staff.

On October 13, 2016, during an interview with Inspector #627, RPN #115 stated that resident #001's care plan did not contain any individualized plan to promote and manage their bladder incontinence based on the assessment. RPN #117 also indicated that resident #001's care plan did not include interventions that promoted continence.

During an interview on October 13, 2016, at 0930 hours with the Inspector, RPN #116 stated that resident #002's care plan had not promoted continence.

During a review of the care plan for resident #003, by RPN #116 and the Inspector, RPN #116 stated that the interventions in place had not promoted continence.

Inspector #627 spoke with RPN #102 who indicated that a continence assessment was completed yearly for each resident; however, residents were not assessed for the potential to restore function.

On October 13, 2016, during an interview with Inspector #627, the Director of Patient Care (DOPC) stated that the home's expectation was that all residents have interventions to promote continence. They confirmed that there was not an assessment of potential to restore function with specific interventions for resident #001, #002 and #003.

NC related to this finding was also issued under WN #8 of this report. [s. 19. (1)]

***Additional Required Actions:***

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

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**WN #3: 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 resident #006's plan of care set out clear

directions to staff and others who provide direct care to the resident.

A Compliance Order (CO) was previously issued during inspection #2015_332575_0020 with regards to resident #006, the licensee was to ensure the following by January 8, 2016:

The licensee shall ensure that resident #001's written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Specifically, the licensee shall ensure:
1. The physician's order provides clear instructions regarding the use of the a restraint, including the purpose of the device and when it is to be applied.
2. A consent is signed that clearly indicates what restraint is to be used and why.
3. The care plan is updated and provides clear direction regarding when staff can apply the restraint, according to the physician's order.

Inspector #542 completed a health care record review for resident #006. The Inspector observed a physician's order, that indicated the resident required specific restraints. A signed consent was also located that indicated all of the required restraints. The resident's current care plan that was accessible to the direct care staff indicated that resident #006 no longer used one of the restraints.

On October 13, 2016, at approximately 1000 hrs, Inspector #542 spoke with TL #102 who stated that resident #006 had not been using the one specific restraint for approximately three weeks and that a new consent was needed. They also stated that the home did not typically have the physician discontinue the restraints when they were no longer needed.

The plan of care had not provided clear directions to staff and others who provided direct care to resident #006. The consent remained outdated without the current information regarding the restraint use, furthermore the physician's order was not accurate according to what was currently being used for resident #006. [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 #002 as specified in the plan.

During stage one of the RQI, resident #002 and their family member informed Inspector #627 that a PSW had been rough while providing care to them. Please refer to WN #2,

finding three for additional information.

A health care record review was completed by Inspector #627 for resident #002. The care plan included specific interventions for staff to use when providing care. The care plan also revealed that resident #002 required assistance with specific care.

A review of the home's investigation notes provided to Inspector #627 by RPN #102 and the DOPC revealed that PSW #106 was removed from resident #002's assignment list and that they received disciplinary action.

Inspector #627 interviewed the DOPC, who indicated that the staff did not follow resident #002's plan of care. [s. 6. (7)]

***Additional Required Actions:***

***CO # - 002 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 care set out in the plan of care for resident #002 is provided as specified in the plan, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,**
**(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).**
**(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).**
**(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).**
**(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).**
**(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).**
**(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).**
**(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).**
**(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports.

Inspector #627 reviewed the home's policy titled "Abuse of Clients-Prevention, Reporting and Elimination" last revised November 17, 2015, which failed to provide an explanation of the duty under section 24 to make mandatory reports.

RPN #113 and the Inspector reviewed the policy titled "Abuse of Clients- Prevention, Reporting and Elimination", last revised November 17, 2015. Although RPN #113 and the Inspector were able to identify areas where it was noted that abuse must be reported immediately, the policy failed to contain an explanation of the duty under section 24 of the Act to make mandatory reports.

During an interview with the Inspector, the DOPC stated that the policy identified that abuse must be reported immediately, however it did not contain of the duty under section 24 of the Act to make mandatory reports. [s. 20. (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 to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

**s. 23. (1) Every licensee of a long-term care home shall ensure that,**
**(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
**(i) abuse of a resident by anyone,**
**(ii) neglect of a resident by the licensee or staff, or**
**(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
**(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
**(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported, was immediately investigated.

During stage one of the RQI, resident #002 and their family member informed Inspector #627 that a PSW had been rough while providing care to them. Please refer to WN #2, finding three for additional information.

During an interview on October 11, 2016, with the Inspector, RPN #115 stated that they became aware of the incident on a specific day and reported it to the DOPC on that same day.

During an interview on October 11, 2016, with the Inspector, the DOPC stated that they were made aware of the incident, by RPN #115 but started their investigation the following day. The DOPC also indicated that they did not report the alleged abuse to the Director. [s. 23. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse, neglect or anything else provided for in the regulations is immediately investigated, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

During stage one of the RQI, resident #002 and their family member informed Inspector #627 that a PSW had been rough while providing care to them. Please refer to WN #2, finding three for additional information.

During an interview on October 11, 2016, with the Inspector, the DOPC stated that they were made aware of the incident, by RPN #115 but started their investigation the following day. The DOPC also indicated that they did not report the alleged abuse to the Director. [s. 24. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is immediately reported to the Director, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001, #002 and #003 who were incontinent received an assessment that included causal factors, patterns, types of incontinence and potential to restore function with specific interventions.

During stage one of the RQI, resident #001, #002 and #003 were identified as frequently incontinent of urine by the Resident Assessment Instrument-Minimum Data Set (RAI-MDS).

A review by Inspector #627 of the form titled, "Appendix A: Bladder and Bowel Continence Assessment" for resident #001, #002 and #003, identified causal factors, patterns and types of incontinence, however it did not contain any potential to restore function with specific interventions for any of the residents.

Inspector #627 reviewed resident #001, #002 and #003's care plan which revealed that all of the residents required some sort of assistance for continence care from staff.

On October 13, 2016, during an interview with Inspector #627, RPN #115 stated that resident #001's care plan did not contain any individualized plan to promote and manage their bladder incontinence based on the assessment. RPN #117 also indicated that resident #001's care plan did not include interventions that promoted continence.

During an interview on October 13, 2016, at 0930 hours with the Inspector, RPN #116 stated that resident #002's care plan had not promoted continence.

During a review of the care plan for resident #003, by RPN #116 and the Inspector, RPN #116 stated that the interventions in place had not promoted continence.

Inspector #627 spoke with RPN #102 who indicated that a continence assessment was completed yearly for each resident; however, residents were not assessed for the potential to restore function.

On October 13, 2016, during an interview with Inspector #627, the Director of Patient Care (DOPC) stated that the home's expectation was that all residents have interventions to promote continence. They confirmed that there was not an assessment of potential to restore function with specific interventions for resident #001, #002 and #003.

***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 resident #001, #002 and #003 who are incontinent receive an assessment that includes causal factors, patterns, types of incontinence and specifically any potential to restore function with specific interventions, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council**

**Specifically failed to comply with the following:**

**s. 56. (1) Every licensee of a long-term care home shall ensure that a Residents' Council is established in the home. 2007, c. 8, s. 56 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a Residents' Council was established in the home.

On October 7, 2016, Inspector #542 interviewed Activity Staff #112 and asked if the home had a Residents' Council. The activity staff #112 indicated that they did not believe that the home had an active Resident's Council.

On October 12, 2016, Inspector met with the DOPC who also indicated that the home did not have a Residents' Council at this time. [s. 56. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a Residents' Council is established in the home, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance**
**Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,**
**(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;**
**(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;**
**(c) identifies measures and strategies to prevent abuse and neglect;**
**(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and**
**(e) identifies the training and retraining requirements for all staff, including,**
**(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and**
**(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified measures and strategies to prevent abuse and neglect.

Inspector #627 reviewed the home’s policy titled “Abuse of Clients-Prevention, Reporting and Elimination” last revised November 17, 2015, which failed to identify any measures and strategies to prevent abuse and neglect.

During an interview with the Inspector, the DOPC confirmed that the home's written policy to promote zero tolerance of abuse and neglect of residents had not contained measures and strategies to prevent abuse and neglect. [s. 96. (c)]

2. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified the training and retraining requirements for all staff including:

i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may have lead to abuse and neglect and how to avoid such situations.

Inspector #627 reviewed the home`s policy titled "Abuse of Clients-Prevention, Reporting and Elimination", last revised November 17, 2015, which failed to identify information regarding the training and retraining to be provided to the staff.

During an interview with the Inspector, the DOPC confirmed that the home's written policy to promote zero tolerance of abuse and neglect of residents did not contain a description of the training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may have lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

***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 written policy to promote zero tolerance of abuse and neglect of residents identifies measures and strategies to prevent abuse and neglect and measures and the training and retraining requirements for all staff, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.**
**Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,**
**(a) use of physical devices; O. Reg. 79/10, s. 109.**
**(b) duties and responsibilities of staff, including,**
**(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,**
**(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.**
**(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.**
**(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.**
**(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.**
**(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.**
**(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's policy titled "Least Restraints" addressed how consent was to be obtained and documented for the use of physical devices to restrain (under s.31) and Personal Assistance Services Device (PASD).

On October 6, 2016, Inspector #542 reviewed the home's policy titled, "Least Restraints," which failed to identify how consent was to be obtained and documented for the use of physical devices to restrain and the use of PASDS. The policy directed the staff to obtain a consent within 24 hours of applying restraint.

Inspector spoke with the DOPC who indicated that all of the required information regarding the consent was missing from the policy. [s. 109. (e)]

***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 policy to minimize restraining of residents contained an explanation of how consent was to be obtained and documented for the use of physical devices to restrain (under s. 31) and the use of PASDs (under s. 33), to be implemented voluntarily.***

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**WN #11: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or systems required to be put in place were complied with.

Resident #005 was identified through the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) as having a low body mass index (BMI) and no nutritional interventions.

Inspector #627 reviewed an order from the Registered Dietitian, which identified that resident #005 was to receive specific nutritional interventions, multiple times daily.

Inspector #627 reviewed the policy titled "Detailed Daily Food and Fluid Intake Record", (undated), which revealed the following:
3) The RPN caring for the resident is responsible for completing the Detailed Daily Food and Fluid Intake record.
5) An order for the specific nutrition supplement is written on the Physician's Order Form by the Registered Dietitian (RD) and the order is processed by nursing who will transcribe the order to the Medication Administration records (MARs). The information is then communicated to the Dietary Department by the Registered Staff.

During an interview with RPN #102, they stated to Inspector #627 that resident #005 had been ordered a specific nutritional intervention multiple times daily, by the RD. The RPN stated that the supplement was documented on the medication administration record (MAR) and on the "Long Term Care Fluid Intake" form.

A review of the MAR and the "Long Term Care Fluid Intake" form by RPN#102 and the Inspector failed to reveal any entries for the specific nutritional intervention. RPN #102 confirmed that the home's expectation was all orders for supplements be transcribed to the MAR, and that all fluids taken by a resident, including a supplement was to be transcribed to the "Long Term Care Fluid Intake" form as per policy and this was not completed for resident #005. [s. 8. (1) (a),s. 8. (1) (b)]

**Issued on this 19th day of January, 2017**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JENNIFER LAURICELLA (542), SYLVIE BYRNES (627) |
| **Inspection No. / No de l'inspection :** | 2016_283542_0005 |
| **Log No. / Registre no:** | 022124-16 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Oct 13, Dec 21, 2016 |
| **Licensee / Titulaire de permis :** | LADY DUNN HEALTH CENTRE<br>17 Government Road, Box 179, Wawa, ON, P0S-1K0 |
| **LTC Home / Foyer de SLD :** | LADY DUNN HEALTH CENTRE<br>17 Government Road, P.O. Box 179, Wawa, ON, P0S-1K0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Kadean Ogilvie-Pinter |

To LADY DUNN HEALTH CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 901

**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 ensure the following are completed to ensure the safety of resident #006 while bed rails are being used:

a) is assessed and their bed system is evaluated in accordance with Health Canada's Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008

b) appropriate interventions are put in place to ensure that resident #006 is safe while in bed

**Grounds / Motifs :**

1. The licensee has failed to ensure that where bed rails were used, resident #006 was assessed and their bed system evaluated in accordance with evidence-based practices, to minimize risk to resident #006.

A previous compliance order (CO) was issued on December 22, 2015 with regards to the bed systems and resident assessments when bed rails were being used.

During stage one of the Resident Quality Inspection (RQI), Inspector #542 observed that numerous residents were using bed rails that had large gaps

within the rails themselves. Inspector #627 and Inspector #542 also observed that the home was replacing some of the home's current bed rails with new ones.

Inspector #542 spoke with maintenance staff # 103 and #104. Both staff members said that all of the bed system assessments were conducted in June 2016 as a result of the last inspection (November 2015). They also indicated that all of the bed's failed the inspections because of the bed rails and the entrapment zones. They provided the inspector with the documentation regarding the bed system assessments.

Inspector #542 reviewed the documentation that was provided which was dated June, 2016. The documentation supported that 16 out of 16 beds failed zone 1 and 14 out of 16 beds failed zone 3 of the entrapment testing. All fails were due to the bed rail designs.

On October 6, 2016, Inspector #542 met with the Director of Patient Care (DOPC). The inspector asked the DOPC if the licensee assessed the resident when bed rails where being used. They indicated that they were not aware that they were required to do this and felt that the overall assessment of the bed system was enough. They also said that the home does not provide this type of an assessment on the resident.

On October 6, 2016, Inspector #542 observed the maintenance staff to be changing a resident's bed system that consisted of different bed rails that contained a large gap between the two rails.

On October 11, 2016, Inspector #627 and #542 were approached by a resident's family member. They expressed their concern that the home changed the resident`s bed system.  After the bed system was changed, the resident suffered a fall from their bed.

Inspector #542 reviewed the resident's health care record. It was documented on the care plan that the resident was at a risk for falls prior to them falling out of bed after their bed system was changed.

Inspector #542 spoke with the DOPC and asked if an assessment was completed for the resident regarding their bed system and the use of the bed rails. The DOPC indicated that no assessment was completed even after the

change of the bed system.

The decision to issue this compliance order was based on the severity which indicated actual harm to the resident and although the scope was determined to be isolated, the home has a previous compliance order related to this same area of the legislation. Despite being aware that an assessment was required to be completed on residents where bed rails are used, the home failed to protect resident #006 from injury. (542)

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

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee shall ensure that all residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff.

Specifically, the licensee shall:

1) Ensure that resident #006 and any other resident are offered their meals.

2) The home will ensure that resident #002, #003, #004, #006, #007, #008 and any other residents who utilize bed rails are assessed for the use of their bed system and are provided with the use of safe bed rails according to best practices.

3) Resident #002 is treated in a manner that respects their choices on how they are cared for according to their care plan.

4) Resident #001, #002 and #003 along with other residents that are incontinent but have the potential to restore function are provided with assistance by the home to promote continence. Each resident shall have an individualized toileting plan in place.

**Grounds / Motifs :**

1. The licensee has failed to ensure that residents of the home were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

Under O.Reg 79/10, neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-

being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Inspector #542 completed a health care record review for resident #006. The current care plan identified that resident #006 required assistance with meals and that the nursing staff were to monitor their intake at all meals and snacks. It was also noted that the Registered Dietitian (RD) documented that resident #006 was at a nutritional risk.

On October 13, 2016 at approximately 1000 hours (hrs), Inspector #542 observed resident #006 in their night clothes, in bed sleeping.

On October 13, 2016 during an interview, Inspector #542 asked RPN #117 why resident #006 remained in bed in their night clothes. They said that it was easier to leave them in bed on their shower day. Inspector #542 then asked if resident #006 had received breakfast. The RPN #117 stated, no but they could give them something, however it was too close to lunch.

Inspector #542 reported the incident to the Director of Patient Care (DOPC) at approximately 1030 hours informing them that resident #006 had not been provided with breakfast. The DOPC said that it was an expectation that staff offer all residents their meals and that this was neglect as they failed to offer resident #006 breakfast.

2. Compliance Order #001 was issued during inspection # 2015_332575_0020. The licensee was to complete the following by February 29, 2016: 1) Conduct bed system assessments for all residents who require the use of bed rails, following the Health Canada guidance document; 2) Train staff on the use of the bed rails and bed system, specifically, zones of entrapment; 3) Maintain a record of the resident assessment and bed system assessment, including the type of mattresses and beds used for each resident; 4) Ensure steps are taken to prevent resident entrapment where dimensional limits exceed the recommended limits.

Under O.Reg 79/10, neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents." The home has shown a pattern

of inaction that jeopardizes the health, safety and well-being of one or more residents by failing to address the risk of entrapment. An immediate compliance order was issued during this inspection as the home failed to complete a resident assessment and that their bed system was evaluated before and after the change of the bed rails which resulted in the resident falling out of their bed (see WN # 1 for further details).

On October 4, 2016, Inspector #542 and Inspector #627 observed resident #002, #003, #004, #006, #007 and #008 to have their bed rails in the guard position. On October 6, 2016, Inspector #542 observed all of the above bed rails to have a large gap within them.

On October 5, 2016 at 1624 hours, during an interview with Inspector #542, the RPN Team Lead (TL) #102 indicated that the maintenance staff had just begun changing the bed rails as a result of last year's inspection and that they were waiting for parts. The TL also said that they did not believe that any other staff member was evaluating the bed systems.

Inspector #542 interviewed maintenance staff #103 and #104. Both staff members said that all of the bed system assessments were conducted in June 2016, as a result of the last Resident Quality Inspection (RQI) in 2015. They also indicated that all of the beds had failed the inspections due to the bed rails and the entrapment zones. They provided the Inspector with the documentation regarding the bed system assessments.

Inspector #542 reviewed the documentation that was provided which was dated June 1-4, 2016. The documentation supported that 16 out of 16 beds failed zone 1 and that 14 out of 16 beds failed zone 3 of the entrapment testing. All fails were due to the bed rail designs. According to the document all of the above mentioned resident bed systems failed both zones 1 and 3.

On October 6, 2016, Inspector #542 interviewed the Director of Patient Care (DOPC) who was the home's Administrator and Director of Care. They informed the Inspector that all of the bed systems failed the zone entrapment testing that was completed by the maintenance staff in June 2016, however they were waiting for the parts in order to change the bed rails. The Inspector asked what the home was doing to ensure resident safety when the bed rails are being used. The DOPC did not answer the question. Inspector #542 informed the DOPC that numerous observations were made in which large gaps on the bed

rails themselves were noted. Inspector #542 asked if the home had developed a plan to ensure that the residents that were at a potential risk for injury had their bed rails changed first. The DOPC said that they did not have a plan. The DOPC also indicated that they were not aware that they were required to assess the residents when bed rails where being used and felt that the overall assessment of the bed system was adequate.

On October 6, 2016, Inspector #542 observed the maintenance staff to be changing a resident's bed system that consisted of different bed rails that contained a large gap between the two rails.

On October 11, 2016, Inspector #627 and #542 were approached by a resident's family member. They expressed their concern that the home changed the resident's bed system. After the bed system was changed, the resident suffered a fall from their bed.

Inspector #542 reviewed the resident's health care record. It was documented on the care plan that the resident was at a risk for falls prior to them falling out of bed after their bed system was changed.

Inspector #542 spoke with the DOPC and asked if an assessment was completed for the resident regarding their bed system and the use of the bed rails. The DOPC indicated that no assessment was completed before or after the change of the bed system.

Previous non-compliance was identified in November 2014 during inspection #2014_339579_0013 where a Voluntary Plan of Correction (VPC) was issued as the licensee failed to take steps to prevent resident entrapment. In December 2015, during inspection #2015_332575_0020 a Compliance Order (CO) was issued with regards to the bed systems and resident assessments when bed rails were being used. The inspection revealed that despite a previous non-compliance the home continued to fail completing any bed system assessments when bed rails where being used. It was also determined that the home was using full bed rails that consisted of large gaps within them. These gaps exceeded the measurements that are set out in the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latch Reliability, and Other Hazards.'

Despite the licensee being aware that all bed systems failed at least one zone of entrapment, they continued to use the bed rails and failed to take steps to prevent resident entrapment. The licensee also failed to ensure that when bed rails were used, residents were assessed with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

3. During stage one of the RQI, resident #002 and their family member informed Inspector #627 that a PSW had been rough while providing care to them. The resident had tears in their eyes while the PSW was performing their care. Furthermore, the resident stated to the family member that the PSW did not fully assist them with specific care. The family member and the resident were unable to identify the date of those occurrences but stated it had occurred "not long ago". The family member had reported both incidents to RPN #115.

A health care record review was completed by Inspector #627 for resident #002. The care plan included specific interventions for staff to use when providing care. The care plan also revealed that resident #002 required one staff to provide assistance with specific care.

A review of the home's investigation notes provided to Inspector #627 by RPN #102 and the DOPC revealed that PSW #106 was removed from resident #002's assignment list and that they received disciplinary action.

During an interview on October 11, 2016, with the Inspector, RPN #115 stated that they became aware of the incident on a specific day and reported it to the DOPC on that same day.

During an interview on October 11, 2016, with the Inspector, the DOPC stated that they were made aware of the incident, by RPN #115 but started their investigation the following day. The DOPC also indicated that they did not report the alleged abuse to the Director.

Non Compliance (NC) related to this finding was also issued under Written Notification (WN) #6 and #7.

4. Under O.Reg 79/10, neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or

well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

During stage one of the RQI, resident #001, #002 and #003 were identified as frequently incontinent of urine by the Resident Assessment Instrument-Minimum Data Set (RAI-MDS).

A review by Inspector #627 of the form titled, "Appendix A: Bladder and Bowel Continence Assessment" for resident #001, #002 and #003, identified causal factors, patterns and types of incontinence, however it did not contain any potential to restore function with specific interventions for any of the residents.

Inspector #627 reviewed resident #001, #002 and #003's care plan which revealed that all of the residents required some sort of assistance for continence care from staff.

On October 13, 2016, during an interview with Inspector #627, RPN #115 stated that resident #001's care plan did not contain any individualized plan to promote and manage their bladder incontinence based on the assessment. RPN #117 also indicated that resident #001's care plan did not include interventions that promoted continence.

During an interview on October 13, 2016, at 0930 hours with the Inspector, RPN #116 stated that resident #002's care plan had not promoted continence.

During a review of the care plan for resident #003, by RPN #116 and the Inspector, RPN #116 stated that the interventions in place had not promoted continence.

Inspector #627 spoke with RPN #102 who indicated that a continence assessment was completed yearly for each resident; however, residents were not assessed for the potential to restore function.

On October 13, 2016, during an interview with Inspector #627, the Director of Patient Care (DOPC) stated that the home's expectation was that all residents have interventions to promote continence. They confirmed that there was not an assessment of potential to restore function with specific interventions for resident #001, #002 and #003.

NC related to this finding was also issued under WN #8 of this report.

Additionally, the home failed to protect residents from abuse and neglect as evidenced by non-compliance identified during this inspection related to:

WN # 4, LTCHA, 2007, s. 3. (1) 3 where the home failed to ensure that residents were not neglected by the licensee or staff. The home failed to offer or provide resident #006 their breakfast as it was their shower/bath day;

WN #1, LTCHA, 2007, O.Reg 79/10, r. 15 where the home failed to ensure that where bed rails were used, residents were assessed and their bed systems evaluated in accordance with evidence-based practices. The home was aware that resident bed systems failed at least one zone of entrapment and continued to the use the bed systems without putting interventions in place to ensure resident safety. Also the home did not provide any resident assessments when bed rails were being used;

WN #8, LTCHA, 2007, O.Reg 79/10, r. 51 (2) (a) where the home failed to ensure that residents that were incontinent received an assessment that include the potential to restore function with specific interventions;

WN #5, LTCHA, 2007, O. Reg 79/10, r. 96 c and e, s. 20. (2) where the home failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained everything set out in the Act and Regulations regarding the policy on Prevention of Abuse and Neglect; and

WN # 7, LTCHA, 2007, s. 23. (1) (a) and s. 24. (1) where the home failed to ensure that every alleged, suspected or witnessed incident of abuse was immediately investigated and reported.

The decision to issue this compliance order was based on the scope which was determined to be a pattern of residents affected, even though the home does not have a compliance history under this area of the legislation, the severity was determined to be actual harm to the health, safety and well-being of residents. (542)

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 06, 2017

**Order # / Ordre no :** 002

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

**Linked to Existing Order / Lien vers ordre existant:** 2015_332575_0020, CO #005;

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall ensure that resident #006's plan of care sets out clear directions to staff and others who provide direct care.

Specifically the licensee shall ensure the following is completed for resident #006;

a) ensure that the plan of care provides clear direction with regards to the all restraints used for resident #006

b) ensure that restraint consents and physician's orders are current and specific for resident #006

**Grounds / Motifs :**

1. The licensee has failed to ensure that resident #006's plan of care set out clear directions to staff and others who provide direct care to the resident.

A Compliance Order (CO) was previously issued during inspection #2015_332575_0020 with regards to resident #006, the licensee was to ensure the following by January 8, 2016:

The licensee shall ensure that resident #001's written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Specifically, the licensee shall ensure:
1. The physician's order provides clear instructions regarding the use of the chest restraint, including the purpose of the device and when it is to be applied.
2. A consent is signed that clearly indicates what restraint is to be used and why.
3. The care plan is updated and provides clear direction regarding when staff can apply the restraint, according to the physician's order.

Inspector #542 completed a health care record review for resident #006. The Inspector observed a physician's order, that indicated the resident required specific restraints. A signed consent was also located that indicated all of the required restraints. The resident's current care plan that was accessible to the direct care staff indicated that resident #006 no longer used one of the restraints.

On October 13, 2016, at approximately 1000 hrs, Inspector #542 spoke with TL #102 who stated that resident #006 had not been using the one specific restraint for approximately three weeks and that a new consent was needed. They also stated that the home did not typically have the physician discontinue the restraints when they were no longer needed.

The plan of care had not provided clear directions to staff and others who provided direct care to resident #006. The consent remained outdated without the current information regarding the restraint use, furthermore the physician's order was not accurate according to what was currently being used for resident #006.

The decision to issue this compliance order was based on the scope which was identified as isolated, the severity which indicated the potential for harm, and the compliance history which despite previous non-compliance issued, non-compliance continued with this section of the legislation.
(542)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 30, 2016

**Order # / Ordre no :** 003

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

**Linked to Existing Order / Lien vers ordre existant:** 2015_332575_0020, CO #004;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan that ensures where bed rails are used, 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 the risk to the resident and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

This plan shall include, but not limited to:

1) A detailed description of how the licensee will ensure that all residents are assessed when bed rails are being used to ensure that the resident's will remain safe.

2) How the licensee will ensure that where bed systems fail the zone entrapment testing, interventions are put in place immediately to eliminate the risk to the resident.

The plan shall also include specified time frames for the development and implementation and identify the staff member (s) responsible for the implementation.

This plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the inspector's attention at (705) 564-3133.

The plan must be submitted by January 6, 2017 and fully implemented by January 13, 2017.

**Grounds / Motifs :**

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During this Resident Quality Inspection (RQI), on October 4, 2016, Inspector #542 and Inspector #627 observed resident #002, #003, #004, #006, #007 and #008 to have their bed rails raised. On October 6, 2016, Inspector #542

observed all of the above bed rails to have a large gap within them.

Inspector #542 spoke with the RPN Team Lead (TL) #102 who indicated that the maintenance staff had just begun changing the bed rails as a result of last year's inspection and that they were waiting for parts. The TL also said that they did not believe that any other staff member was evaluating the bed systems.

Inspector #542 spoke with maintenance staff #103 and #104. Both staff members said that all of the bed system assessments were conducted in June 2016, as a result of the last RQI inspection in 2015. They also indicated that all of the beds had failed the inspections due to the bed rails and the entrapment zones. They provided the inspector with the documentation regarding the bed system assessments. Inspector #542 reviewed the documentation that was provided which was dated June 1-4, 2016. The documentation supported that 16 out of 16 beds failed zone 1 and that 14 out of 16 beds failed zone 3 of the entrapment testing. All fails were due to the bed rail designs. According to the document all of the above mentioned resident bed systems failed both zones 1 and 3.

Inspector #542 spoke with the Director of Patient Care (DOPC) who is the home's Administrator and Director of Care. They informed the Inspector that all of the bed systems failed the zone entrapment testing that was completed by the maintenance staff in the summer, however they are waiting for the parts in order to change the bed rails. Inspector asked if the home was doing anything in the meantime to ensure resident safety when the bed rails are being used. The DOPC did not answer the question. Inspector #542 informed her that numerous observations were made in which large gaps on the bed rails themselves were noted. Inspector #542 asked if the home had developed some kind of a plan to ensure that the resident's that were at a potential risk for injury had their bed rails changed first. The DOPC said that they had not come up with any type of a plan but they would do so now.

On October 6, 2016, Inspector #542 met with the Director of Patient Care (DOPC). The inspector asked the DOPC if the licensee assessed the residents when bed rails where being used. They indicated that they were not aware that they were required to do this and felt that the overall assessment of the bed system was enough.

On October 6, 2016, Inspector #542 observed the maintenance staff to be

changing a resident's bed system that consisted of different bed rails that contained a large gap between the two rails.

On October 11, 2016, Inspector #627 and #542 were approached by a resident's family member. They expressed their concern that the home changed the resident`s bed system. After the bed system was changed, the resident suffered a fall from their bed.

Inspector #542 reviewed the resident's health care record. It was documented on the care plan that the resident was at a risk for falls prior to them falling out of bed after their bed system was changed.

Inspector #542 spoke with the DOPC and asked if an assessment was completed for the resident regarding their bed system and the use of the bed rails. The DOPC indicated that no assessment was completed even after the change of the bed system.

Despite the licensee being aware that all bed systems failed at least one zone of entrapment, they continued to use the bed rails and failed to put anything in place to prevent resident entrapment. The licensee also failed to ensure that when bed rails are used, residents are assessed with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

The decision to re-issue this compliance order was based on the severity, scope and compliance history. The severity was determined to be a potential for actual harm to the health, safety and well-being of residents and the scope was a pattern as it has the potential to affect those resident's who require the use of bed rails. A previous related compliance order was issued in 2015 during the Resident Quality Inspection and non-compliance (NC) in 2014, however NC continues in this area of the legislation. (542)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 13, 2017

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 13th day of October, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Jennifer Lauricella

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