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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 1, 2016	2016_413500_0006	010491-16	Resident Quality Inspection

Licensee/Titulaire de permis

MARIANN NURSING HOME AND RESIDENCE
9915 YONGE STREET RICHMOND HILL ON L4C 1V1

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

MARIANN HOME
9915 YONGE STREET RICHMOND HILL ON L4C 1V1

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

NITAL SHETH (500), NICOLE RANGER (189), THERESA BERDOE-YOUNG (596)

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): April 13, 14, 15, 18, 19, 20, 21, 22, 25, 27, and 28, 2016.

The following intakes were inspected concurrently during this RQI: Critical Incident (CI) intake # 004063-15, #017984-15, #018042-15, #027977-15, #006942-15, and follow-up intake #018700-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Dietary Manager (DM), Occupational Therapist (OT), Physiotherapist (PT), Physiotherapy Assistant (PTA), Program Manager, Maintenance Technician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Activity Aide, Dietary Aide (DA), House-keeping Aides, Summer Students, President of the Residents' Council and Family Council, Residents, and Family Members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, meal service delivery, infection prevention and control practices, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **22 WN(s)**
- **6 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents had a screen and cannot be opened more than 15 centimetres.

A review of the Compliance Order (CO) #001 issued under the Residents' Quality Inspection (RQI)# 2015_297558_0003 revealed that the home was found with a number of identified windows that opened more than 15 centimeters.

The order issued to the licensee included to implement a plan to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

On April 21, 2016, the inspector tested the window in an identified room, and the window was found to open greater than 30 centimeters. Upon closer observations, the inspector observed a window blocker in place. The inspector was able to manipulate the window blocker lever in order for the window not be opened more than 15 centimeters. Resident #013, who was present in the room with the inspector, revealed that his roommate resident #014 will often go and open the window.

Interview and observation with the Administrator on April 21, 2016, confirmed that the window was able to open greater than 30 centimeters. The Administrator also revealed that he is aware that staff will often manipulate the lever to open the windows fully to air the rooms. The Administrator confirmed that all windows in the home have the same window blocker mechanisms.

The severity of the non-compliance and the severity of the harm was minimal harm to potential for actual harm.

The scope of the non-compliance was widespread.

A review of the Compliance History revealed the following non-compliances related to the Long-Term Care Homes Act, 2007, r. 16.

A Written Notification (WN) and a Compliance Order (CO) were previously issued for r. 16., during inspections #2015_297558)0003, dated February 15, 2015. [s. 16.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

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

i. kept closed and locked,

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

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

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

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

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a

resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked and equipped with a door access control system that is kept on at all times.

On April 21, 2016 at 1014 hours, the inspector was exiting the south service stairwell onto the main floor. As the inspector opened the door to the main floor, the inspector observed resident #011 half way out the exit door with his/her walker. PSW# 122 came and brought the resident back inside the home.

Record review and staff interview revealed that an identified resident exhibits exit seeking behaviour on a daily basis over the past eight months.

The identified resident was found walking outside in the parking lot on an identified date in November 2015. Staff interviews revealed that the resident will open the main floor south side exit door 2-3 times per shift. The door located on the main floor south side that is accessible to residents, led to an unsecure outdoor area that led to the parking lot and a busy street. When tested by the inspector, the door was not locked and not equipped with a door access control system.

During the inspection period, the inspector observed the basement doors leading to the east and south stairways unlocked. These stairways led to emergency doors that were unlocked and led to the outside of the home. Residents were observed accessing the basement for activity programs.

The Activities Manager also reported to the inspector that there are a few residents who are able to come down to the basement on their own.

Interview with the Administrator revealed that quotes were obtained from outside party for a maglock system in March 2015 and March 2016. The Administrator reported that the home is planning to install the maglock system to the main floor south side door in September 2016.

The severity of the non-compliance and the severity of the harm was minimal harm to potential for actual harm.

The scope of the non-compliance was isolated.

A review of the Compliance History revealed the following non-compliances related to the

Long- Term Care Homes Act, 2007, r. 9. (1). [s. 9. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and are addressed, including height and latch reliability.

Observation on April 22, 2016, at 1130 hours and a review of the document entitled, "Bedside Rails", dated April 12, 2016, revealed that resident #003, #009, #020, #029, #031 and #032 are using half rails for transferring and repositioning.

A review of resident #003's care plan revealed that the resident needs assistance with transferring and ambulation.

A review of resident #009 and #020's care plan revealed staff to instruct residents to use appropriate rails for transferring and repositioning.

A review of resident #029's care plan directed staff to remind the resident to turn and reposition every two hours when in bed. The resident has half rails that are up when

he/she is in bed to aid with bed mobility.

A review of resident #031’s care plan revealed that the resident required assistance for bed mobility and staff to remind him/her to reposition every two hours when he/she is in the bed.

A review of resident #032’s care plan revealed that the resident required assistance to restore function to maximum self-sufficiency for mobility and directed staff to show the resident how to position own body parts when in the bed or in the chair.

Interview with PSW #106, #108, #123, and RPN #104 confirmed that the above mentioned residents are using half rails for transferring and repositioning.

A review of the home’s “Facility Entrapment Inspection Sheet” dated June 6, 2016, revealed 36 beds out of 64 were failed in zone 1 and 4, and 54 out of 64 beds were failed in zone 4. Resident #003, #029, and #032’s beds were failed in zone 1 and 4. Resident #009, #020, and #031’s beds were failed in zone 4.

A review of the home’s policy entitled “Use of Bedrails”, revised July 2015, indicated the maintenance department will ensure that side rails are in good working order and fasten securely to the bed.

Interview with the RAI- Coordinator revealed that the home identified that the majority of their beds could not pass the entrapment inspection, therefore, the home has started replacing rails with soft rails. At present, the home has applied soft rails to twelve residents' beds on the third floor. The home did not take steps to address safety risk for the rest of the beds identified in the entrapment inspection.

Interview with the administrator revealed that the home does not have an action plan with timelines to address the safety risk issue identified during the bed entrapment inspection report. Twelve residents’ bed rails were removed and replaced with soft rails. Other residents are still using beds with failure zones and the home did not take steps to address safety risk identified though the entrapment inspection report.

The severity of the non-compliance and the severity of the harm was minimal harm to potential for actual harm.

The scope of the non-compliance was widespread.

A review of the Compliance History revealed that there was no non-compliance issued related to the Long-Term Care Homes Act, 2007, r. 15. (1) (b). [s. 15. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Observation in April 2016 revealed that PSW #106 wiped resident #001's mouth and PSW #108 wiped resident #018's mouth with a clothing protector.

PSW #106, #108, RN #109 and the dietary manager confirmed that they should use paper napkins to wipe the resident's mouth to maintain the resident's dignity and respect. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident's right to have his or her lifestyle and choices respected is fully respected and promoted.

A record review of a Critical Incident (CI) report submitted by the home to the Ministry of Health and Long-term care (MOHLTC) to report an allegation of abuse, reported that Activity Assistant #126 did not acknowledge a cultural preference request during care provided to resident #021.

Record review of resident #021's plan of care outlined a cultural preference that the resident did not wish to be in close proximity to opposite gender residents in the common areas of the home.

Record review of the home's investigation notes revealed that an identified staff observed Activity Aide #126 place resident #021 in the elevator with opposite gender resident, even though he/she was aware that the resident and the family did not want the resident to be in the elevator with the opposite gender resident.

Interview with resident #021 revealed that due to cognitive impairment, he/she was unable to recall and discuss the incident.

Interview with the Programs Manager, Administrator, Activity Aide #142, Summer Students #133, and #125 reported that they were aware of the resident's cultural preference and accommodated his/her request by not placing him/her in the elevator with the opposite gender resident or seating him/her with the opposite gender resident during meal service.

Interview with Activity Aide #126 revealed that he/she was aware of the resident's cultural preference and denied ever placing him/her in the elevator with the opposite gender resident.

Interviews with Activity Aide #142, Summer Students #133, and #125 confirmed that they observed Activity Aide #126 place resident #021 in the elevator with the opposite gender resident in July 2015. When Summer Student #133 reminded Activity Aide #126 not to do it, Activity Aide #126 continued to transport the resident in the elevator with three opposite gender residents. [s. 3. (1) 19.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted:

-every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity

-every resident has the right to have his or her lifestyle and choices respected is fully respected and promoted, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Record review and interview with the Administrator regarding 24 hour nursing care confirmed the following:

There was no registered nurse on duty at the home on the following dates and times:

0700 hours and 1500 hours: March 6, 19, 20 27, 2016, April 2, 3, 16, 17, 23, 24, 2016.

2300 hours, and 0700 hours: March 27, 2016.

Interview with registered staff #109, the DOC and the Administrator revealed it was the home's practice that the DOC is on call every other weekend on the day shift. [s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times.

In April 2015, on two different occasions, the inspector observed resident #003's call bell behind the bed and not within reach and inaccessible.

A review of resident #003's plan of care revealed that the call bell cord should be within reach.

Interview with the resident revealed that he/she is often not able to find his/her call bell as it has fallen behind the bed and cannot be reached. Resident #003 recalled the incident when he/she was not able to find the call bell in the room, so he/she pulled the call bell in the bathroom and was instructed by staff not do so unless it is an emergency.

Interview and observation by registered staff #109 confirmed that the call bell was not accessible to the resident and placed the call bell on the bed. Registered staff #109 also confirmed that he/she did overhear staff member telling the resident not to pull the call bell in the washroom when the resident was not able to find the call bell in the room.

Interview with the DOC revealed that the home's expectation is that resident call bell must be within reach and accessible at all times. [s. 17. (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 the resident-staff communication response system can be easily seen, accessed, and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #7: 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 were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Record review of CI was submitted to the MOHLTC by the home in July 2015 to report alleged verbal abuse towards resident #022.

Record review of the home's investigation notes revealed that three summer students collectively wrote a letter of concern and submitted it to the management of the home, alleging abuse of resident #022 by Activity Aide #126.

Record review of the home's interview notes revealed that Summer Student #141 observed Activity Aide #126 pointing in resident #022's face and arguing during his/her work placement in the home in the summer of 2015.

Interview with resident #022 revealed that he/she could not recall the alleged incidents of verbal abuse by Activity Aide #126, as a lot of time had passed.

Interview with summer student #132 revealed that on an identified date in the summer of 2015, during a work placement in the home, he/she observed resident #022 in the activity room complaining that he/she did not want to attend the activity. Activity Aide #126 then spoke to summer student #132, loud enough for resident #022 to hear, referring to the resident in an inappropriate manner and complained about him/her. Another staff member, who was nearby, removed the resident from the activity room and took him/her back upstairs.

Interview with Summer Student #133 revealed that on identified dates in the summer of 2015, during a work placement in the home, he/she observed Activity Aide #126 yelling at resident #022 in the corridor in front of staff and other residents.

Interview with Activity Assistant #126 revealed that he/she denied verbally abusing

resident #022.

Record review of the home's investigation notes and interview with the administrator revealed that Activity Aide #126 was suspended from work for a period of time for verbal abuse towards resident #022, and attended retraining on abuse, resident rights, bullying and harassment in the workplace and abuse and violence training and then returned to work.

Interview with the Programs Manager and Activity Aide #126 revealed that Activity Aide #126 still continues to work with resident #022. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that persons who have received training under subsection (2) received retraining in infection prevention and control at times or at intervals provided for in the regulations.

Record review of the home's Infection Prevention and Control training records for 2015 revealed that seven out of 85 staff did not receive the training.

Interview with the home's administrator confirmed that seven casual staff out of a total of 85 staff did not receive training on Infection Prevention and Control in 2015. [s. 76. (4)]

2. The licensee has failed to ensure that persons who have received training under subsection (2) receive retraining in the following:
-The Residents' Bill of Rights
-The home's policy to promote zero tolerance of abuse and neglect of residents
-The duty to make mandatory reports under section 24
-The whistle-blowing protections.

Record review of the home's staff educational training records revealed that seven out of eighty five staff were not trained on Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protections in 2015.

Interview with the administrator confirmed that seven casual staff out of eighty five staff did not receive the above mentioned annual retraining in 2015. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff have received retraining annually relating to the following:
-the Infection Prevention and Control
-the Residents' Bill of Rights
-the home's policy to promote zero tolerance of abuse and neglect of residents
-the duty to make mandatory reports under section 24 and
-the whistle-blowing protection, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of the annual Infection Prevention and Control program evaluation was kept that included the following: the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented.

Record review of the home's annual Infection Prevention and Control Program evaluation for 2015 and interview with the DOC revealed that the dates changes were implemented, were not mentioned in the evaluation. [s. 229. (2) (e)]

2. The licensee has failed to ensure that staff participate in the implementation of the Infection Prevention and Control Program.

On April 13, 2016, the inspector observed an unlabeled comb, stored in the shower room that is shared by all residents.

Interview with registered staff #109 confirmed that resident's personal items should be labelled, limiting the potential infection risk to residents. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record of the annual Infection Prevention and Control program evaluation is kept that includes the following: the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented, to be implemented voluntarily.

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

Findings/Faits saillants :

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

On April 18, 2016, the inspector observed one quarter side rail up on resident #008's bed.

Record review of resident #008's care plan and kardex did not mention side rails use.

Interview with RPN #100 and PSW #101 revealed that resident #008 uses two side rails, when in the bed and that the resident's plan of care was not revised to include the use of side rails. [s. 6. (10) (b)]

WN #11: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Record review of CI report revealed that the home submitted a report of an allegation of abuse from an identified staff towards resident #022 in July 2015 and updated the CI 12 days later. The CI did not include the outcome of the home's investigation.

Interview with the Administrator confirmed that the home amended the CI on the above mentioned date, however, did not further update the CI to report the outcome of the home's abuse investigation. [s. 23. (2)]

WN #12: 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 the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm that any had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Record review of a CI report revealed that it was first submitted to the MOHLTC on July 15, 2015, for notification of suspected abuse of two identified residents.

Record review of the home's investigation notes and interview with the Administrator revealed that the home became aware of the allegations of abuse on July 8, 2015, and did not report it to the director until July 15, 2015. [s. 24. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the safety risk with respect to the resident.

Observation on April 22, 2016, at 1130 hours and on April 27, 2016, at 0930 hours revealed that resident #018's bed has soft rails applied.

A review of the resident's care plan revealed that the resident uses soft rails to prevent a risk for the fall.

A review of the document entitled, "Bedside Rails", dated April 12, 2016, revealed that the resident uses soft rails.

A review of the resident's clinical records revealed that there was no assessment completed for the resident using soft rails.

Interview with PSW #108 confirmed that the resident is using soft rails from the last couple of months.

Interview with RN #109 revealed that there was no assessment completed for the use of soft rails for the resident.

Interview with Occupational Therapist (OT) revealed that he/she did not complete the assessment because it was a trial and he/she was thinking to discontinue the soft rails. [s. 26. (3) 19.]

WN #14: 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. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Observation in April 2016 revealed that resident #017 and #018 were served soup on the table without feeding assistance available.

A review of resident #017's MDS assessment dated, January 2016, revealed the resident required total assistance for eating.

A review of resident #017's care plan revealed that the resident required constant encouragement and total feeding during eating.

A review of resident #018's MDS assessment dated February 2016, revealed the resident required total assistance.

A review of resident #018's care plan revealed that the resident required total feeding assistance.

A review of the home's policy entitled "Services of Food to residents that need assistance" indicated no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Interview with dietary aide #107, PSW #106, #108, RN #109, and the dietary manager revealed that residents should not be served soup without feeding assistance being available. [s. 73. (2) (b)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and copies of the inspection reports from the past two years for the long-term care home is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements.

Record review and staff interview with the Administrator confirmed that copies of the inspection reports from the past two years for the long-term care home and the long-term care home's policy to promote zero tolerance of abuse and neglect of residents are not posted in the home. [s. 79. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping, procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs.

On April 13, 2016, the inspector observed the shower chair in the third floor shower room to be visibly soiled with mildew.

Staff interviews revealed that the shower chairs are cleaned by the PSW staff, and the home's process is to clean the shower chair with a disinfectant spray before and after use.

Interview and observation by registered staff #109 on April 13, 2016 confirmed that the shower chair had mildew, and the registered staff reported that she removed the backing of the shower chair and sent it to the laundry for cleaning immediately. [s. 87. (2) (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

On April 13, 2016, the inspector observed two hazardous cleaning solutions on top of the toilet in the shower room on the main floor, accessible to residents. Interview with registered staff #116 confirmed the hazardous solution should not be kept on top of the toilet and she proceeded to remove the solution from the toilet. [s. 91.]

WN #18: 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 contained procedures and interventions to support residents who have been abused or neglected or allegedly abused or neglected.

Record review of the home's policy on Abuse, revised January 2014, section II human resources from the Nursing Services administration manual, did not include interventions to support residents who have been abused or neglected or allegedly abused or neglected.

Interview with the administrator confirmed that the above mentioned policy did not include interventions to support residents who have been abused or neglected or allegedly abused or neglected. [s. 96. (a)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Record review of Critical Incident (CI) report submitted to the MOHLTC in July 2015 to report an allegation abuse of resident #021 and #022 indicated that the home had informed the residents' SDMs about the allegations of abuse.

Record review of the home's investigation notes and resident #021 and #022's progress notes did not include documentation reflecting that the above mentioned residents' SDMs were notified.

Interviews with resident #021's SDM and resident #022's SDM revealed that they were not aware of the allegations of abuse, and the home did not notify them. [s. 97. (1) (b)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date that the changes and improvements were implemented, was promptly prepared.

Record review of the home's annual Zero Abuse and Neglect Program evaluation for 2015 revealed that the dates that the changes and improvements were implemented, were not included in the evaluation.

Interview with the Administrator confirmed that the dates that the changes and improvements were implemented, were not included in the home's annual zero abuse and neglect program evaluation for 2015. [s. 99. (e)]

WN #21: 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 written policy under section 29 of the Act deals with the use of physical devices.

Observation on April 22, 2016, at 1130 hours, revealed 12 residents on the third floor had soft rails applied to their beds.

Interview with PSW #106, #108, RPN #104, RN #109 confirmed that soft rails are used for these 12 residents for prevention of falls.

A review of the home's policy entitled "Use of Bedrails", revised July 2015, revealed that the policy did not indicate the use of soft rails for residents.

Interview with RN #109 revealed that the home recently started replacing bed rails with soft rails and therefore the home did not have a formal policy and procedure set up for the use of soft rails for residents.

Interview with the RAI Coordinator and the Administrator confirmed that the home does not have a policy on the soft rails. [s. 109. (a)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training is provided to all staff who provide direct care to residents: for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

A review of the home's education record and interview with the RAI coordinator and the Administrator revealed that not 100% of staff received the education on least restraint. The training on the application of PASD was included in the least restraint education. 11.76% of casual staff did not receive training on PASD. [s. 221. (1) 6.]

Issued on this 30th day of June, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NITAL SHETH (500), NICOLE RANGER (189), THERESA BERDOE-YOUNG (596)
Inspection No. / No de l'inspection :	2016_413500_0006
Log No. / Registre no:	010491-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 1, 2016
Licensee / Titulaire de permis :	MARIANN NURSING HOME AND RESIDENCE 9915 YONGE STREET, RICHMOND HILL, ON, L4C-1V1
LTC Home / Foyer de SLD :	MARIANN HOME 9915 YONGE STREET, RICHMOND HILL, ON, L4C-1V1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bernard Boreland

To MARIANN NURSING HOME AND RESIDENCE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_297558_0003, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee shall equip all windows in resident rooms and windows in the home with a window blocker that cannot be easily manipulated by anyone, to ensure windows cannot be opened more than 15 centimetres.

Grounds / Motifs :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents had a screen and cannot be opened more than 15 centimetres.

A review of the Compliance Order (CO) #001 issued under the Residents' Quality Inspection (RQI)# 2015_297558_0003 revealed that the home was found with a number of identified windows that opened more than 15 centimeters.

The order issued to the licensee included to implement a plan to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

On April 21, 2016, the inspector tested the window in an identified room, and the window was found to open greater than 30 centimeters. Upon closer observations, the inspector observed a window blocker in place. The inspector was able to manipulate the window blocker lever in order for the window to not open more than 15 centimeters. Resident #013, who was present in the room with the inspector, revealed that his roommate resident #014 will often go and

open the window.

Interview and observation with the Administrator on April 21, 2016, confirmed that the window was able to open greater than 30 centimeters. The Administrator also revealed that he is aware that staff will often manipulate the lever to open the windows fully to air the rooms. The Administrator confirmed that all windows in the home have the same window blocker mechanisms.

The severity of the non-compliance and the severity of the harm was minimal harm to potential for actual harm.

The scope of the non-compliance was widespread.

A review of the Compliance History revealed the following non-compliances related to the Long-Term Care Homes Act, 2007, r. 16.

A Written Notification (WN) and a Compliance Order (CO) were previously issued for r. 16., during inspections #2015_297558)0003, dated February 15, 2015. [s. 16.] (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

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

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

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

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

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

Order / Ordre :

The licensee shall,
1. Equip the exit door located on the main floor, south side with a door access control system and an audible back up alarm that connects to the resident-staff communication and response system.
2. Equip the south and east basement stairwell doors, to which residents have access, with a door access control system and back up door alarm that are connected to the resident-staff communication and response system.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked and equipped with a door access control system that is kept on at all times.

On April 21, 2016 at 1014 hours, the inspector was exiting the south service stairwell onto the main floor. As the inspector opened the door to the main floor, the inspector observed resident #011 half way out the exit door with his/her walker. PSW# 122 came and brought the resident back inside the home.

Record review and staff interview revealed that an identified resident exhibits exit seeking behaviour on a daily basis over the past eight months.

The identified resident was found walking outside in the parking lot on an identified date in November 2015. Staff interviews revealed that the resident will open the main floor south side exit door 2-3 times per shift. The door located on the main floor south side that is accessible to residents, led to an unsecure outdoor area that led to the parking lot and a busy street. When tested by the inspector, the door was not locked and not equipped with a door access control system.

During the inspection period, the inspector observed the basement doors leading to the east and south stairways unlocked. These stairways led to emergency doors that were unlocked and led to the outside of the home. Residents were observed accessing the basement for activity programs.

The Activities Manager also reported to the inspector that there are a few residents who are able to come down to the basement on their own.

Interview with the Administrator revealed that quotes were obtained from outside party for a maglock system in March 2015 and March 2016. The Administrator reported that the home is planning to install the maglock system to the main floor south side door in September 2016.

The severity of the non-compliance and the severity of the harm was minimal harm to potential for actual harm.

The scope of the non-compliance was isolated.

A review of the Compliance History revealed the following non-compliances related to the Long- Term Care Homes Act, 2007, r. 9. (1). [s. 9. (1)] (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with r. 15. (1) (b) to ensure that where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment identified during bed entrapment inspection, 2015; including height and latch reliability.

The plan shall provide the following:
-an outline of the home's immediate, short-term and long-term strategies to prevent entrapment risk for residents using bed rails with as bed system failed in any zones.
-a process that ensures staff monitor residents' safety who are using bed rails with a bed system that failed in any zones.
-an outline of how the home will educate all staff who provide care to residents on bed safety. The education at a minimum shall include information related to how residents are assessed for bed rail use, when to apply bed rails, how to recognize when a bed is unsafe, how and when to report bed safety concerns, bed entrapment zones 1-4, and how to apply any entrapment zone interventions if necessary.

The plan shall be submitted by June 30, 2016, via email to nital.sheth@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and are addressed, including height and latch reliability.

Observation on April 22, 2016, at 1130 hours and a review of the document entitled, "Bedside Rails", dated April 12, 2016, revealed that resident #003, #009, #020, #029, #031 and #032 are using half rails for transferring and repositioning.

A review of resident #003's care plan revealed that the resident needs assistance with transferring and ambulation.

A review of resident #009 and #020's care plan revealed staff to instruct residents to use appropriate rails for transferring and repositioning.

A review of resident #029's care plan directed staff to remind the resident to turn

and reposition every two hours when in bed. The resident has half rails that are up when he/she is in bed to aid with bed mobility.

A review of resident #031's care plan revealed that the resident required assistance for bed mobility and staff to remind him/her to reposition every two hours when he/she is in the bed.

A review of resident #032's care plan revealed that the resident required assistance to restore function to maximum self-sufficiency for mobility and directed staff to show the resident how to position own body parts when in the bed or in the chair.

Interview with PSW #106, #108, #123, and RPN #104 confirmed that the above mentioned residents are using half rails for transferring and repositioning.

A review of the home's "Facility Entrapment Inspection Sheet" dated June 6, 2016, revealed 36 beds out of 64 were failed in zone 1 and 4, and 54 out of 64 beds were failed in zone 4. Resident #003, #029, and #032's beds were failed in zone 1 and 4. Resident #009, #020, and #031's beds were failed in zone 4.

A review of the home's policy entitled "Use of Bedrails", revised July 2015, indicated the maintenance department will ensure that side rails are in good working order and fasten securely to the bed.

Interview with the RAI- Coordinator revealed that the home identified that the majority of their beds could not pass the entrapment inspection, therefore, the home has started replacing rails with soft rails. At present, the home has applied soft rails to twelve residents' beds on the third floor. The home did not take steps to address safety risk for the rest of the beds identified in the entrapment inspection.

Interview with the administrator revealed that the home does not have an action plan with timelines to address the safety risk issue identified during the bed entrapment inspection report. Twelve residents' bed rails were removed and replaced with soft rails. Other residents are still using beds with failure zones and the home did not take steps to address safety risk identified though the entrapment inspection report.

The severity of the non-compliance and the severity of the harm was minimal

harm to potential for actual harm.

The scope of the non-compliance was widespread.

A review of the Compliance History revealed that there was no non-compliance issued related to the Long-Term Care Homes Act, 2007, r. 15. (1) (b). [s. 15. (1) (b)] (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2016

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 1st day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nital Sheth

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