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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 19, 2018	2018_543561_0007	009294-18	Resident Quality Inspection

Licensee/Titulaire de permis

Canadian Reformed Society for a Home for the Aged Inc.
c/o Mount Nemo Christian Nursing Home 4486 Guelph Line BURLINGTON ON L7P 0N2

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

Mount Nemo Christian Nursing Home
4486 Guelph Line BURLINGTON ON L7P 0N2

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

DARIA TRZOS (561), BERNADETTE SUSNIK (120), CATHY FEDIASH (214), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 10, 11, 14, 15, 16, 17, 18, 22, 23, 24, 25, 28, 2018

The following Critical Incident System (CIS) Inspection was completed concurrently with this Resident Quality Inspection (RQI):
004743-18 - related to staff to resident alleged abuse

Inspector #696 was present for the duration of the RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), Food Services Supervisor (FSS), Registered Dietitian (RD), Maintenance Coordinator, Resident Assessment Instrument (RAI) Coordinators, Bookkeeper/Administrative Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), President of the Family Council, President of the Resident Council, Personal Support Workers (PSWs), housekeeping staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed meal service, observed the provision of care, reviewed relevant documents including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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

- **15 WN(s)**
- **5 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Emotional Abuse is defined in the Long Term Care Homes Act, 2007, Ontario Regulation 79/10, as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks performed by anyone other than a resident.

A Critical Incident System (CIS) report 2577-000003-18 was submitted to the Director related to alleged staff to resident abuse, stating that on an identified date in 2018, resident #014 was found by nursing staff restrained with the use of prohibited devices.

The home's investigation notes were reviewed by LTCH Inspector #561. The investigation notes indicated that resident #014 was found by registered staff #106 restrained with prohibited devices.The investigation indicated that the alleged PSW #115 admitted to these acts and stated in the interview with the home that they did this to prevent resident #014 from demonstrating inappropriate behaviour.

PSW #115 was interviewed during this inspection and admitted to these actions. PSW stated that resident #014 was cognitively impaired and was not aware of what had happened.

The DRC was interviewed by Inspectors #561 and #696, and indicated that the conclusion of the investigation was a misapplication of the restraint by PSW #115. PSW #115 was disciplined; however no formal re-training provided to the PSW related to abuse and neglect or minimizing of restraining.

Although, resident #014 was cognitively impaired, the actions of the PSW did constitute emotional abuse, which is defined as any actions of insulting, intimidating or humiliating gestures.

The licensee failed to ensure that resident #014 was protected from abuse by staff of the home.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #004743-18, conducted concurrently during the Resident Quality Inspection (RQI). [s. 19. (1)]

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. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, that the bed system was evaluated in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices have been identified by the Ministry of Health and Long Term Care, as a document produced by Health Canada (HC) entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. This guidance document provides recommendations relating to bed systems and bed accessories in order to reduce life-threatening entrapments associated with adult hospital bed systems. It characterizes the body parts at risk for entrapment, identifies the locations of bed openings that are potential entrapment areas, and recommends dimensional criteria for bed rails. In addition, the HC guide provides guidance with measuring bed systems with a weighted cone and cylinder tool to identify whether any of the four identified entrapment zones fail the dimensional criteria. The four entrapment zones are within the bed rail and areas between the mattress and the bed rail.

Additionally, the HC guide makes reference to a document which provides recommendations on how to mitigate the risk posed by beds which do not meet the recommendations designed to reduce life-threatening entrapments. This document is

entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment", and is available as a link from the U.S. Food and Drug Administration (FDA) website.

A) The licensee purchased the weighted cone and cylinder tool to complete a bed system evaluation for entrapment zones 1 through 4 of all resident bed systems between January 10 and 12, 2018. During an inspection on May 23, 2018, three different bed styles from three different manufacturers were noted in the home. One identified style in particular was of concern. The bed rails were designed to rotate into more than one position. When in the highest position (transfer or assist position) the bed rails appeared to have a large space between the bed rail and the side of the mattress. When the Maintenance Coordinator was requested to re-test the four zones, using the weighted tool, zone 3 did not pass entrapment. The mattress keepers were included on the bed system and applied by the Maintenance Coordinator just prior to testing [but were not applied by nursing staff as required]. According to the HC guidance document, bed rails that have more than one position (an intermediate or high and low locking positions) would need to be tested in each of the locked positions. According to the Maintenance Coordinator, none of the bed systems that included bed rails that could be locked into more than one position, were tested in each position for entrapment zones 2 and 3.

B) Bed systems manufactured by a specified provider were predominate in the home, which included rotating assist rails that could rotate and lock into three positions. In addition, some of the bed models, when purchased over 15 years prior, did not include any mattress keepers to keep the mattress from sliding side to side. When bed rails were tight and mattress keepers were in place, no gaps were evident between the mattress and the bed rail in any locked position. However, when the bed rails were loose and a properly sized and applied mattress keepers were not in place, gaps were evident. Bed rails were hand tested for stability on May 23 and 24, 2018, in several rooms throughout the home. The bed rails in an identified room were observed to be quite unstable and wobbly. On May 11, 2018, LTCH Inspector #561 observed bed systems in two room which did not have any mattress keepers and on May 17, 2018, beds in two identified rooms were noted without mattress keepers. When the mattresses were pushed by hand, they slid side to side. The mattress on the bed frame in an identified room was observed sitting on top of recently installed mattress keepers on May 23, 2018, and did not fit properly between the keepers. The Maintenance Coordinator stated to LTCH Inspector #120 that they manufactured the keepers by themselves and applied them after LTCH Inspector #561 identified that they were missing. According to the documentation provided by the Maintenance Coordinator six bed systems, when

evaluated between January 10 and 12, 2018, were identified to have missing mattress keepers but no action was taken at the time. The Maintenance Coordinator reported to LTCH Inspector #120 on May 23, 2018, that bed rails were routinely tightened and on a schedule; however, some of the bed rail hardware (nuts, bolts etc.) could not be tightened. In addition, the Maintenance Coordinator stated that the nursing staff were not reporting the loose bed rails as they arose [based on a lack of documentation in the maintenance log], and nursing staff were not aware of the issue of potential entrapment zones from shifting mattresses. According to the DOC on May 24, 2018, the PSWs did not receive any training on the various bed system hazards.

C) A bed system was noted in an identified room with two padded bed rails attached to the bed frame. According to the resident #002's plan of care and to RN #108, both bed rails were required to be applied when the resident was in bed. Both bed rails were padded to prevent resident injury. The bed rails were noted to be rounded on each end (foot and head ends), and the mattress was soft. The records kept and provided by the Maintenance Coordinator included that the bed rails were measured on May 15, 2018, after a new mattress was provided and that zone 4 (rail ends) passed entrapment. The Maintenance Coordinator was requested by LTCH Inspector #120 to re-measure the zone on May 23, 2018, as observed by LTCH Inspector #120 the bed failed zone 4. According to RN#108, one additional bed with the same length bed rails was also in use in the home. The padding applied to the bed rail would not have mitigated the identified risk in zone 4.

The concerns related to the above noted bed system hazards and potential for resident risk were raised with the Administrator and Maintenance Coordinator during the inspection on May 23 and 24, 2018, and options discussed, as identified in the document "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment. [s. 15. (1) (a)]

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. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee failed to ensure that no prohibited restraint devices, that limit movement, were used in the home.

CIS report 2577-000003-18 was submitted to the Director related to an alleged staff to resident physical abuse, stating that on an identified date in 2018, nursing staff found resident #014 to be restrained with prohibited devices.

The home's investigation notes were reviewed by LTCH Inspector #561. The investigation notes indicated that resident #014 was found to be restrained by prohibited devices by PSW #115.

The alleged PSW #115 was interviewed during the investigation and the investigative notes indicated that the PSW admitted to actions and stated that they had done this to prevent the resident from demonstrating a responsive inappropriate behaviour.

RPN #106 was interviewed by the LTCH Inspector, and they confirmed that they went to resident #014's room on the identified date and found the resident to be restrained with prohibited devices and removed them immediately.

During interview with PSW #115, they confirmed that they used prohibited restraint on the resident to prevent them from demonstrating an inappropriate behaviour. PSW #115 was aware that this was a prohibited device and did receive education on the use of restraints prior to the incident.

The clinical record review indicated that resident #014 was not interviewable. Inspectors #561 and #696 attempted to interview the resident; however, were not able to due to resident's cognitive impairment.

DRC #101 told Inspectors #696 and #561 that the PSW used a prohibited devices intended to limit resident #014's movement and this should not have been used.

The licensee failed to ensure that the prohibited devices were not used in the home.

This area of non-compliance was identified during a CIS Inspection, log #004743-18, conducted concurrently during the RQI. [s. 112.]

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During a review of medication incidents for an identified period of time in 2018, the following was identified:

A) A review of a medication incident indicated that on an identified date in 2018, the narcotic/controlled drug count for resident #019's routine prescribed drugs, one tablet of an identified drug at different times and one tablet of another drug at different times, was identified as being inaccurate.

During an interview with registered staff #106, they acknowledged that they made an error. The staff member indicated that they recorded on the narcotic/controlled drug count that they administered the drug, which resulted in the count of the resident's prescribed controlled drugs to be inaccurate.

Registered staff #106 indicated that shift count on an identified date in 2018, was conducted with themselves and the incoming registered staff. The staff member indicated the count was not done properly as both nurses had not physically checked the name of the medication to the amount of medication on hand. The medication incident was identified later the same day.

A review of the medication incident, resident's clinical records and interview with the

DRC indicated that no ill effects were sustained to resident #019 as a result.

An interview with the DRC and registered staff #106, confirmed that drugs had not been administered to resident #019 in accordance with the directions for use specified by the prescriber.

B) A review of a medication incident indicated that on an identified date in 2018, resident #015 had not received their routine prescribed drugs. A review of the medication incident indicated that the resident was prescribed to receive different medications at different times of the day.

An interview with registered staff #119, indicated that they were newly hired and had overlooked administering the medications identified above.

A review of the medication incident, resident's clinical records and interview with the DRC indicated that no ill effects were sustained to resident #015 as a result.

An interview with the DRC and registered staff #119 confirmed that drugs had not been administered to resident #015 in accordance with the directions for use specified by the prescriber.

C) A review of resident #016's Medication Administration Record (MAR) indicated that they were prescribed a medication every 72 hours for an identified diagnosis.
A review of the resident's MAR indicated that the resident last received their prescribed medication on an identified date in February 2018.
A review of a medication incident, indicated that resident #016 received their prescribed medication, one day earlier than prescribed.

An interview with registered staff #110, indicated that the monthly MAR is circled every 72 hours identifying the dates the resident's medication is to be administered for the month. The staff member indicated that the MAR had been circled with the wrong starting date. The staff member indicated that at the time of administration, they did not have the previous MAR with them to check the last administration date.

The staff member indicated during an interview, that the physician was notified. Review of the resident's clinical record documentation, indicated that the physician had been made aware of the medication incident and orders were received. Documentation titled, Physician Notes Note, indicated that there were no concerns and they had been made

aware of this medication incident and to continue current management. [s. 131. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care that set out the planned care for the resident.

A CIS report 2577-000003-18 was submitted to the Director on an identified date in 2018, related to an alleged staff to resident physical abuse, stating that on an identified date in 2018, nursing staff found resident #014 to be restrained with prohibited devices. Through the investigation completed by the home it was identified that PSW #115 performed these actions in an effort to minimize inappropriate behaviour. The PSW #115 stated in the interview with the LTCH Inspectors #561 and #696, that resident #014 always had this behaviour. PSW #116 was interviewed and stated that resident #014 always had the behaviour.

The clinical records were reviewed and a progress note made by RN #121 on an identified date in 2017, stated that the resident had the inappropriate behaviour. PSW staff tried to minimize the behaviour with inappropriate actions. RN #121 was interviewed, by Inspectors #561 and #696, and stated that they did document resident's inappropriate behaviour and currently the resident continues to have this behaviour.

The DRC was interviewed, and stated that they were not aware of resident #014's behaviour; however, if the staff had documented that the resident had this behaviour it should have been included in the written plan of care and interventions developed.

The licensee failed to ensure that the written plan of care set out the planned care for the resident.

This area of non-compliance was identified during a CIS Inspection, log #004743-18, conducted concurrently during the RQI. [s. 6. (1) (a)]

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

A CIS report 2577-000003-18 was submitted to the Director on an identified date in 2018, related to an alleged staff to resident abuse, and a use of prohibited devices. Through the investigation completed by the home it was identified that PSW #115 used prohibited restrained devices on resident #014 to prevent an inappropriate behaviour.

PSW #115 was interviewed by LTCH Inspectors #561 and #696, and admitted to the actions that were specified in the home's investigation notes. They indicated that resident #014 always demonstrated these behaviours and that registered staff were aware of this. Registered staff #106 was interviewed by Inspector #561 and #696, and stated that they aware of some of the behaviours but not to this degree.

The clinical records were reviewed and no re-assessments of behaviours were found after the incident had occurred. The plan of care was not reviewed and revised and no interventions were developed to address the inappropriate behaviour. This behaviour was not identified in the plan of care after the incident.

The DRC was interviewed and stated that they were not aware of resident #014's

behaviours. The DRC stated that resident #014 was not re-assessed no new interventions were implemented.

The licensee failed to ensure that the resident was re-assessed and plan of care reviewed and revised when resident's care needs changed after the incident.

This area of non-compliance was identified during a CIS Inspection, log #004743-18, conducted concurrently during the RQI. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was not restrained for the convenience of the staff.

A CIS report 2577-000003-18 was submitted to the Director on an identified date in 2018, related to an alleged staff to resident abuse, stating that on an identified date in 2018, nursing staff found resident #014 to be restrained with prohibited devices.

The home's investigation notes were reviewed by LTCH Inspector #561 on May 15, 2018. The investigation notes indicated that resident #014 was found by registered staff #106 restrained with prohibited devices. They immediately released the restraint and reported this incident to the DRC and Administrator.

The alleged PSW #115 was interviewed during the investigation completed by the DRC and the Administrator and the investigative notes indicated that the PSW admitted to this act. They had done that to minimize resident #014's inappropriate behaviour.

During the interview with PSW #115, conducted by LTCH Inspector #561 and #696, they confirmed that used the prohibited restraining devices to prevent resident from demonstrating inappropriate behaviour. They added that they were tired as they had worked a double shift and wanted to prevent resident #014 from repeating their behaviour.

The clinical record review indicated that resident #014 was cognitively impaired. LTCH Inspectors #561 and #696 attempted to interview resident #014; however, were not able to due to their cognitive impairment.

DRC told LTCH Inspectors #696 and #561 that PSW#115 restrained the resident out of convenience to prevent inappropriate behaviour demonstrated by resident #014. They further stated that PSW #115 failed to report resident's behaviour to the registered staff, therefore, no alternative interventions were tried.

The licensee failed to ensure that resident #014 was not restrained for the convenience of the staff.

This area of non-compliance was identified during a CIS Inspection, log #004743-18, conducted concurrently during the RQI. [s. 30. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is not restrained for the convenience of the staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that where restraining by a physical device was included in a resident's plan of care, that alternatives to restraining the resident were considered and tried where appropriate, but were not effective or would not have been effective to address the risk referred to in paragraph 1.

The plan of care last revised on an identified date in 2018, for resident #002 included the requirement for the resident to be restrained using bed rails to prevent them from falling off their bed. The resident's plan of care identified that the bed rails were used as a restraint since an identified date in 2005.

The licensee's restraint policy, revised February 2017, identified the use of a hi/lo bed and a falls impact mat in order to reduce the risk of any injury from falls from bed. The policy also included using alternative safety measures unless they had been proven to be ineffective and documented as such. For resident #002, the use of specified devices as restraints in preventing serious bodily injury could not be justified as alternative safety measures were not trialled or documented. According to RPN #102, the devices were applied at the request of the resident's substitute decision maker without first following the legislative requirements to try appropriate alternatives.

According to RPN #102, since 2005, no alternatives had been trialled as the devices were considered effective for falls prevention. According to the resident #002's restraint assessment, dated on an identified date in 2018, no restraint reduction strategies were documented and no attempts were made to reduce the use of the restraint.

In addition, resident #002's devices were confirmed to be a safety risk for the resident, after they were re-evaluated by the Maintenance Co-ordinator.

The licensee failed to ensure that alternatives to restraining were considered and tried for resident #002. [s. 31. (2) 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 where restraining by a physical device is included in a resident's plan of care, that alternatives to restraining the resident are considered and tried where appropriate, but were not effective or would not have been effective to address the risk referred to in paragraph 1, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

During stage one of the RQI, resident #006 was observed to have an altered skin

integrity with a dressing covering it.

A review of the resident's progress notes and an interview with PSW staff #124, indicated that on an identified date in 2018, the resident had demonstrated a responsive bahaviour that resulted in an alteration of the skin integrity.

A review of the resident's clinical record indicated that a referral to the Registered Dietitian (RD) had not been completed.

An interview with RN #114, indicated that referrals to the RD were written in the daily planner binder on a form titled, "Dietitian Communication Form" and that the RD reviewed the forms weekly when they were at the home.

A review of the Dietitian Communication Forms were conducted with the DOC and the Food Service Supervisor (FSS). The DRC and FSS confirmed that no referrals for resident #006, had been completed.

The DRC confirmed that the RD had been present at the home since the resident sustained the skin alteration and that resident #006 had not been assessed by the RD as a referral to notify the RD had not been completed. [s. 50. (2) (b) (iii)]

2. The licensee failed to ensure that the resident, who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #013 acquired an area of altered skin integrity on an identified date in 2018, as it was recorded in their clinical records. During the review of resident #013's clinical records it was indicated that monitoring and weekly skin assessments were initiated and recorded in the Assessment Tab in Point Click Care (PCC) and were completed up until a specific date in 2018. A weekly skin assessment in Observation Data section contained a statement indicating that the area was unchanged. A review of the clinical record for resident #013 revealed that between an identified period of time, no weekly skin assessments had been completed and no records that the skin assessment was discontinued were identified.

It was confirmed during an interview with RPN #102, that skin assessments for resident #013 were not completed, which was confirmed by the DRC and acknowledged by the Administrator. RPN #102 also indicated after visual observation of the residents' altered

skin integrity on an identified date in 2018, that it should be continued for one or two more weeks.

The licensee failed to ensure that resident #013, who exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented and to ensure that every resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to the residents received, as a condition to continuing to have contact with residents, annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of skin and wound care in accordance with O. Reg. 79/10, s. 221(1)2.

An interview with the DRC on May 24, 2018, confirmed that only 11.8 Percent (%) of nursing staff, who provided direct care to the residents received as a condition of continuing to have contact with residents, annual retraining in the area of skin and wound care in 2017. On May 25, 2018, the Administrator acknowledged that not all direct care staff had received training on skin and wound care. [s. 76. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive as a condition to continuing to have contact with residents, annual retraining in the area of skin and wound, to be implemented voluntarily.

WN #10: 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 failed to ensure that the home was equipped with a resident-staff communication and response system that, (e) was available in every area accessible by residents.

During the initial tour of the home, it was noted that the large and small dining rooms located in East Wing home area were not equipped with a resident-staff communication and response system accessible by residents. Interview with the Maintenance Coordinator, confirmed that a resident-staff communication and response system was not installed in the large and small dining rooms. The Administrator, when interviewed, acknowledged that the large and small dining rooms were not equipped with communication and response systems accessible by residents. The resident-staff communication and response system was installed in the large and small dining rooms by the Maintenance Coordinator during the inspection. [s. 17. (1) (e)]

WN #11: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A) The Long Term Care Homes Act, 2007, Ontario Regulation 79/10, r. 96 (a) states that every licensee shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

The licensee's policy titled "Abuse and Neglect of Residents: Preventing, Reporting and Eliminating", Policy number C-19-01, re-written November 13, 2017, last reviewed March 5, 2018 indicated that registered staff were to complete a physical exam of the resident to determine any injuries and registered staff were responsible for documenting the assessment, and the care and treatment, provided in the resident's chart in Point Click Care (PCC).

On an identified date in 2018,the home submitted a CI report 2577-000003-18 to the Director related to an alleged staff to resident abuse, stating that on an identified date in 2018, nursing staff found resident #014 to be restrained with prohibited devices. The investigation notes indicated that the resident did not sustain any injuries.

The clinical records were reviewed by LTCH Inspector #561, for resident #014 and the assessment or any information related to what treatment if any were provided could not be found in PCC.
Registered staff #106 was interviewed, and stated that they did assess the resident after the incident and no injuries were observed. They stated that they thought that they

documented this assessment in PCC; however, when reviewed PCC they were not able to find the documentation.

The DRC was interviewed, and indicated that it was an expectation that an assessment after this incident was to be documented in PCC and acknowledged the policy was not complied with.

B) The Long Term Care Homes Act, 2007, Ontario Regulation 79/10, r. 96 (b) states that the licensee's written policy to promote zero tolerance of abuse and neglect of residents needs to contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents.

The licensee's policy titled "Abuse and Neglect of Residents: Preventing, Reporting and Eliminating", Policy number C-19-01, re-written November 13, 2017, last reviewed March 5, 2018, indicated the following:
Results of the investigation: If the investigation indicates there exists a strong suspicion but no conclusive proof that abuse/neglect has occurred:
- If a staff member or volunteer was implicated in the allegation their performance will be closely monitored and they will receive education regarding abuse/neglect prevention (in addition to the mandatory annual education).
If the investigation indicates there is evidence to support the allegation:
- The home will continue with disciplinary action as deemed appropriate"

On an identified date in 2018,the home submitted a CI report 2577-000003-18 to the Director related to an alleged staff to resident abuse, stating that on an identified date in 2018, nursing staff found resident #014 to be restrained with prohibited devices.
The home's investigation notes were reviewed by the LTCH Inspector #561 and indicated that resident was found by registered staff #106 restrained with a prohibited devices. They immediately released the resident and reported this incident to the DRC and Administrator.

The PSW #115 was interviewed by LTCH Inpsectors #561 and #696, and confirmed this incident occurred and admitted to being responsible for the actions as outlined.

The home's investigation and evaluation of the incident indicated that disciplinary measures were put in place and individual training was provided to PSW #115. It also stated that home wide training would be scheduled to take place in September 2018.

The DRC was interviewed by Inspectors #561 and #696 and indicated that the conclusion of the investigation was a misapplication of the restraint by PSW #115. The PSW was disciplined, verbal coaching from the DRC which included an explanation of what the PSW did was wrong and the actions were considered restraining. There was no formal re-training provided to the PSW related to abuse and neglect or minimizing of restraining.

In an interview with the Administrator on May 24, 2018, they indicated that PSW #115 was not monitored after they returned to their regular shift,

The licensee failed to ensure that the abuse and neglect policy was complied with related to the documentation of the assessment in PCC and dealing with persons who have abused or neglected or allegedly abused or neglected residents in the home.

This area of non-compliance was identified during a CIS Inspection, log #004743-18, conducted concurrently during the RQI. [s. 20. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The LTCH Inspector #632 reviewed the annual evaluation of the Skin and Wound Care Program for 2016 and it did not include a summary of the changes made and the date that those changes were implemented.

The DRC in an interview, indicated that the 2016 Skin and Wound Care Program's objectives and their annual evaluation were reviewed on June 20, 2017. DRC confirmed that the goals and objectives (plan for improvement) did not include a summary of the changes made and the date that those changes were to be implemented. The Administrator in an interview, acknowledged that the home's 2016 Skin and Wound Program annual evaluation did not include a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 4.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was dressed appropriately, suitable to the time of day and in accordance with their preferences, in their own clean clothing.

During stage one of the RQI, LTCH Inspectors #561 and #696 observed resident #014 dressed in an inappropriate clothing for the day sitting in the hallway.

PSW #115 and PSW #116 were interviewed and stated that the resident wore this clothing at night. PSW #116 indicated that the night clothing that resident was provided by the SDM was too warm for resident #014 and this was why the home used this clothing.
Resident #014 was not able to be interviewed due to their cognitive impairement.

The clinical records were reviewed and did not indicate why the resident was wearing this specific clothing and whether the SDM consented to the resident wearing it. The written plan of care in effect at the time of this inspection, did not have this preference included.

The DRC was interviewed by LTCH Inspectors #561 and #696, and stated that they were not aware of why the resident was wearing this clothing at night and if the SDM had consented to the use of it.

The licensee failed to ensure that the resident was dressed appropriately in accordance with their preferences and in their own clothing.

This area of non-compliance was identified during a CIS Inspection, log #004743-18, conducted concurrently during the RQI. [s. 40.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

During a tour of the home on May 11, 2018, it was observed in an identified resident room, that the washroom fixtures had not been kept free of corrosion.

On May 14, 2018, the hot water tap in the washroom of the identified room, was observed with a buildup of a white coloured substance and the cold water tap was observed with a buildup of a white and light green coloured substance that had extended into the bowl of the sink.

During a conversation with PSW #104, they indicated that staff were to document in the maintenance request binder, any corroded or worn bathroom taps and that this information may also be recorded when the home conducts their Health and Safety walkthroughs. The staff member indicated that the home has been replacing sinks and taps; however, the taps and sink in the identified room had been this way for some time.

A review of the maintenance request binder on May 14, 2018, indicated that maintenance requests dating from February 10 – May 14, 2018, were present. All entries were reviewed and noted that none contained a request regarding the corrosion to the bathroom taps and sink in the identified room.

A review of the Health and Safety checklist that the home uses and titled, "MNCNH (Mount Nemo Christian Nursing Home) Monthly Workplace Inspection Report" form indicated that there were no areas on the checklist for the staff conducting the inspection to identify any taps or sinks that were corroded.

An interview with the Maintenance Coordinator on May 14, 2018, confirmed that the taps and sink in the identified room were extensively corroded. The Maintenance Coordinator indicated that housekeeping were to document corrosion of washroom fixtures in the maintenance request book and that no requests for the room, had been entered.

A review of the home’s policy titled "Maintenance (Environmental manual)", dated with a revised date of August 2015, had identified preventative maintenance criteria; however, had not contained specific items to inspect related to the home’s preventative maintenance. During an interview with the Maintenance Coordinator on May 14, 2018, they provided the home’s preventative maintenance checklist, titled, “Maintenance Checklist For: Monthly”. A review of this document indicated that washroom fixtures had not been listed on the home’s preventative maintenance schedule. The Maintenance Coordinator confirmed that this was not part of the home’s preventative maintenance checklist and indicated that this would be added.

The Maintenance Coordinator confirmed that procedures had not been developed and implemented to ensure that all washroom fixtures were kept free of corrosion. The Maintenance Coordinator confirmed, that the home had taken action and replaced the taps and sinks in the specified room. [s. 90. (2) (d)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that once in every calendar year the home conducted an evaluation to determine the effectiveness of the policy, and failed to identify what changes and improvements were required to minimize restraining and ensure that restraining was done in accordance with the Act and Regulation.

The annual program evaluation for the Minimizing of the Restraining program was requested by LTCH Inspector from the DRC and they had indicated that the home had not completed the evaluation for year 2017. The DRC confirmed in an interview with the prior DRC who worked in the home in year 2016 that the annual evaluation of this program was not completed for year 2016. The latest program evaluation of the Minimizing of the Restraining program was completed by the home for year 2015.

The licensee failed to ensure that the home conducted an evaluation of the restraints program to determine effectiveness of the policy once in every calendar year. [s. 113. (b)]

Issued on this 27th day of August, 2018

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) :	DARIA TRZOS (561), BERNADETTE SUSNIK (120), CATHY FEDIASH (214), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2018_543561_0007
Log No. / No de registre :	009294-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 19, 2018
Licensee / Titulaire de permis :	Canadian Reformed Society for a Home for the Aged Inc. c/o Mount Nemo Christian Nursing Home, 4486 Guelph Line, BURLINGTON, ON, L7P-0N2
LTC Home / Foyer de SLD :	Mount Nemo Christian Nursing Home 4486 Guelph Line, BURLINGTON, ON, L7P-0N2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Plantinga

To Canadian Reformed Society for a Home for the Aged Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 must be compliant with s.19 (1) of the LTCHA, 2007.

Specifically, the licensee must:
1. Ensure that resident #014 and all other residents in the home, are protected from emotional and any other type of abuse by anyone.
2. Ensure that PSW #115 is provided with re-training on the abuse and neglect policy. The home shall maintain records of the training.
3. Ensure that the home takes appropriate actions in dealing with incidents of abuse as indicated in the home's abuse and neglect policy, specifically related to monitoring of the staffs' performance. The home shall maintain records of the actions undertaken.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Emotional Abuse is defined in the Long Term Care Homes Act, 2007, Ontario Regulation 79/10, as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks performed by anyone other than a resident.

A Critical Incident System (CIS) report 2577-000003-18 was submitted to the Director related to alleged staff to resident physical abuse, stating that on an identified date in 2018, resident #014 was found by nursing staff restrained with the use of prohibited devices.

The home's investigation notes were reviewed by LTCH Inspector #561. The

investigation notes indicated that resident #014 was found by registered staff #106 restrained with prohibited devices.The investigation indicated that the alleged PSW #115 admitted to these acts and stated in the interview with the home that they did this to prevent resident #014 from demonstrating inappropriate behaviour.

PSW #115 was interviewed during this inspection and admitted to these actions. PSW stated that resident #014 was cognitively impaired and was not aware of what had happened.

The DRC was interviewed by Inspectors #561 and #696, and indicated that the conclusion of the investigation was a misapplication of the restraint by PSW #115. PSW #115 was disciplined; however no formal re-training provided to the PSW related to abuse and neglect or minimizing of restraining.

Although, resident #014 was cognitively impaired, the actions of the PSW did constitute emotional abuse, which is defined as any actions of insulting, intimidating or humiliating gestures.

The licensee failed to ensure that resident #014 was protected from abuse by staff of the home.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the resident. The scope of the issue was a level 1 as it related to one resident. The home had a level 5 history as they had multiple NC with at least one related order to the current area of concern issued under this section on November 3, 2017 (2017_689586_0007).

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #004743-18, conducted concurrently during the Resident Quality Inspection (RQI). (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.15(1)(a) of O. Reg. 79/10.

Specifically, the licensee must;

a) Re-evaluate all specified beds using the weighted cone and cylinder tool in accordance with "**"**Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008, to determine if zone 3 passes or fails when the bed rail is in the transfer or upright most position. Ensure that mattress keepers have been applied before conducting the measurement. Contact the bed manufacturer to determine options to mitigate zone 3 entrapment zones. At a minimum, the gap can be filled with a wedge or gap filler. If zone 3 cannot be mitigated in any way, the bed rail must be removed and any resident requiring a bed rail relocated to a bed system that passes all zones of entrapment.
b) Bed systems that are equipped with three quarter length bed rails where zone 4 does not pass, shall be mitigated in accordance with "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment", or equip the bed systems with a different bed rail that passes zones 1 to 4.
c) Equip specified bed systems with mattress keepers that will keep the mattress from sliding side to side and will allow the mattress to fit properly between the keepers.

d) Replace the rail padding identified on two specified beds and other beds where the padding does not tightly and properly fit around the shape of the bed rail.
e) Equip specified bed systems with bed rails that will not loosen easily after multiple uses and will remain tight after adjustments. All similar bed systems shall be re-evaluated to determine if the hardware (bolts, washers, nuts) for the bed rails can be replaced with hardware that is suitable for the intended use of the bed rail.
f) Provide face to face training to all Personal Support Workers (PSWs) on the following as a minimum:
1. The location of the 7 zones of entrapment on each type of bed system in the home (Joerns, Carroll and Arjohuntleigh)
2. How each zone of entrapment is capable of harming a resident.
3. How to ensure that mattresses are fitted properly (by applying mattress keepers or ensuring that after beds are made, mattresses are fitted properly between mattress keepers).
4. How to determine when bed rails are not in good condition and how and when to report the concern.
5. The use of and application, if necessary, of various bed accessories (gap fillers, rail pads, wedges etc.)
6. What specific behaviours, habits and sleep patterns PSWs are required to report to registered staff after observing residents in bed with bed rails applied (as it relates to bed safety risks).
7. The legal requirements related to bed safety in Ontario.
8. The importance of following the resident's plan of care for the application of bed rails and reporting any changes in the resident's bed rail use to the registered staff.
9. The reasons why bed rails are used by residents and their risks and benefits.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, that the bed system was evaluated in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices have been identified by the Ministry of Health and Long Term Care, as a document produced by Health Canada (HC) entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. This guidance document provides recommendations relating to bed systems and bed accessories in order to

reduce life-threatening entrapments associated with adult hospital bed systems. It characterizes the body parts at risk for entrapment, identifies the locations of bed openings that are potential entrapment areas, and recommends dimensional criteria for bed rails. In addition, the HC guide provides guidance with measuring bed systems with a weighted cone and cylinder tool to identify whether any of the four identified entrapment zones fail the dimensional criteria. The four entrapment zones are within the bed rail and areas between the mattress and the bed rail.

Additionally, the HC guide makes reference to a document which provides recommendations on how to mitigate the risk posed by beds which do not meet the recommendations designed to reduce life-threatening entrapments. This document is entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment", and is available as a link from the U.S. Food and Drug Administration (FDA) website.

A) The licensee purchased the weighted cone and cylinder tool to complete a bed system evaluation for entrapment zones 1 through 4 of all resident bed systems between January 10 and 12, 2018. During an inspection on May 23, 2018, three different bed styles from three different manufacturers were noted in the home. One identified style in particular, was of concern. The bed rails were designed to rotate into more than one position. When in the highest position (transfer or assist position) the bed rails appeared to have a large space between the bed rail and the side of the mattress. When the Maintenance Coordinator was requested to re-test the four zones, using the weighted tool, zone 3 did not pass entrapment. The mattress keepers were included on the bed system and applied by the Maintenance Coordinator just prior to testing [but were not applied by nursing staff as required]. According to the HC guidance document, bed rails that have more than one position (an intermediate or high and low locking positions) would need to be tested in each of the locked positions. According to the Maintenance Coordinator, none of the bed systems that included bed rails that could be locked into more than one position, were tested in each position for entrapment zones 2 and 3.

B) Bed systems manufactured by a specified provider were predominate in the home, which included rotating assist rails that could rotate and lock into three positions. In addition, some of the bed models, when purchased over 15 years prior, did not include any mattress keepers to keep the mattress from sliding side to side. When bed rails were tight and mattress keepers were in place, no gaps

were evident between the mattress and the bed rail in any locked position. However, when the bed rails were loose and a properly sized and applied mattress keepers were not in place, gaps were evident. Bed rails were hand tested for stability on May 23 and 24, 2018, in several rooms throughout the home. The bed rails in an identified room were observed to be quite unstable and wobbly. On May 11, 2018, LTCH Inspector #561 observed bed systems in two room which did not have any mattress keepers and on May 17, 2018, beds in two identified rooms were noted without mattress keepers. When the mattresses were pushed by hand, they slid side to side. The mattress on the bed frame in an identified room was observed sitting on top of recently installed mattress keepers on May 23, 2018, and did not fit properly between the keepers. The Maintenance Coordinator stated to LTCH Inspector #120 that they manufactured the keepers by themselves and applied them after LTCH Inspector #561 identified that they were missing. According to the documentation provided by the Maintenance Coordinator six bed systems, when evaluated between January 10 and 12, 2018, were identified to have missing mattress keepers but no action was taken at the time. The Maintenance Coordinator reported to LTCH Inspector #120 on May 23, 2018, that bed rails were routinely tightened and on a schedule; however, some of the bed rail hardware (nuts, bolts etc.) could not be tightened. In addition, the Maintenance Coordinator stated that the nursing staff were not reporting the loose bed rails as they arose [based on a lack of documentation in the maintenance log], and nursing staff were not aware of the issue of potential entrapment zones from shifting mattresses. According to the DOC on May 24, 2018, the PSWs did not receive any training on the various bed system hazards.

C) A bed system was noted in an identified room with two padded bed rails attached to the bed frame. According to the resident #002's plan of care and to RN #108, both bed rails were required to be applied when the resident was in bed. Both bed rails were padded to prevent resident injury. The bed rails were noted to be rounded on each end (foot and head ends), and the mattress was soft. The records kept and provided by the Maintenance Coordinator included that the bed rails were measured on May 15, 2018, after a new mattress was provided and that zone 4 (rail ends) passed entrapment. The Maintenance Coordinator was requested by LTCH Inspector #120 to re-measure the zone on May 23, 2018, as observed by LTCH Inspector #120 the bed failed zone 4. According to RN#108, one additional bed with the same length bed rails was also in use in the home. The padding applied to the bed rail would not have mitigated the identified risk in zone 4.

The concerns related to the above noted bed system hazards and potential for resident risk were raised with the Administrator and Maintenance Coordinator during the inspection on May 23 and 24, 2018, and options discussed, as identified in the document "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment.

The scope of the non-compliance included a pattern (level 2), as some of the resident bed systems were not evaluated in accordance with prevailing practices, the severity of the non-compliance had the potential to cause harm to residents related to their bed systems (level 2) and the history (level 5) of non-compliance included a Compliance Order that was issued under the same section on November 3, 2017 (2017_689586_0007). (120)

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 112. For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Order / Ordre :

The licensee must be compliant with s. 112 of the O.Reg 79/10.

Specifically, the licensee must:

1. Ensure that resident #014 and any other resident in the home are not restrained in any way with the use of prohibited devices.
2. Ensure that PSW #115 is re-trained on the Restraint Policy and the home shall maintain records of this training.
3. Ensure that PSW #115 reviews Residents' Bill of Rights and completes a reflective practice related to the actions of restraining resident #014 with the prohibited device. The home shall maintain records of this in their employee file.
4. Ensure that resident #014 is re-assessed and the assessment shall be documented in resident's clinical records related to resident's responsive behaviour. Ensure that the resident's SDM is involved in the assessment of the resident.
5. Ensure the SDM is made aware of the interventions put in place to prevent such incidents from occurring.

Grounds / Motifs :

1. The licensee failed to ensure that no prohibited restraint devices, that limit movement, were used in the home.

CIS report 2577-000003-18 was submitted to the Director related to an alleged staff to resident physical abuse, stating that on an identified date in 2018, nursing staff found resident #014 to be restrained with prohibited devices.

The home's investigation notes were reviewed by LTCH Inspector #561. The investigation notes indicated that resident #014 was found to be restrained by prohibited devices by PSW #115.

The alleged PSW #115 was interviewed during the investigation and the investigative notes indicated that the PSW admitted to actions and stated that they had done this to prevent the resident from demonstrating a responsive inappropriate behaviour.

RPN #106 was interviewed by the LTCH Inspector, and they confirmed that they went to resident #014's room on the identified date and found the resident to be restrained with the prohibited device and removed it immediately.

During interview with PSW #115, they confirmed that they used a prohibited restraint on the resident to prevent them from demonstrating an inappropriate behaviour. PSW #115 was aware that this was a prohibited device and did receive education on the use of restraints prior to the incident.

The clinical record review indicated that resident #014 was not interviewable. Inspectors #561 and #696 attempted to interview the resident; however, were not able to due to resident's cognitive impairment.

DRC #101 told Inspectors #696 and #561 that the PSW used a prohibited devices intended to limit resident #014's movement and this should not have been used.

The licensee failed to ensure that the prohibited devices were not used in the home.

The severity of this issue was determined to be a level 2 as there was potential harm to the resident. The scope of the issue was a level 1 as it related to one resident. The home had prior history with unrelated non-compliances.

This area of non-compliance was identified during a CIS Inspection, log #004743-18, conducted concurrently during the RQI. (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s. 131(2).

Specifically, the licensee must:

1. Ensure that residents #016 and #019 and all other residents prescribed to receive narcotics and controlled drugs, are administered the narcotics and controlled drugs in accordance with the directions for use specified by the prescriber.

2. Ensure that resident #015 and all other residents prescribed to receive routine drugs, are administered the routine drugs in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During a review of medication incidents for an identified period of time in 2018, the following was identified:

A) A review of a medication incident indicated that on an identified date in 2018, the narcotic/controlled drug count for resident #019's routine prescribed drugs, one tablet of an identified drug at different times and one tablet of another drug at different times, was identified as being inaccurate.

During an interview with registered staff #106, they acknowledged that they made an error. The staff member indicated that they recorded on the

narcotic/controlled drug count that they administered the drug, which resulted in the count of the resident's prescribed controlled drugs to be inaccurate.

Registered staff #106 indicated that shift count on an identified date in 2018, was conducted with themselves and the incoming registered staff. The staff member indicated the count was not done properly as both nurses had not physically checked the name of the medication to the amount of medication on hand. The medication incident was identified later the same day.

A review of the medication incident, resident's clinical records and interview with the DRC indicated that no ill effects were sustained to resident #019 as a result.

An interview with the DRC and registered staff #106, confirmed that drugs had not been administered to resident #019 in accordance with the directions for use specified by the prescriber.

B) A review of a medication incident indicated that on an identified date in 2018, resident #015 had not received their routine prescribed drugs. A review of the medication incident indicated that the resident was prescribed to receive different medications at different times of the day.

An interview with registered staff #119, indicated that they were newly hired and had overlooked administering the medications identified above.

A review of the medication incident, resident's clinical records and interview with the DRC indicated that no ill effects were sustained to resident #015 as a result.

An interview with the DRC and registered staff #119 confirmed that drugs had not been administered to resident #015 in accordance with the directions for use specified by the prescriber.

C) A review of resident #016's Medication Administration Record (MAR) indicated that they were prescribed a medication every 72 hours for an identified diagnosis.
A review of the resident's MAR indicated that the resident last received their prescribed medication on an identified date in February 2018.
A review of a medication incident, indicated that resident #016 received their prescribed medication, one day earlier than prescribed.

An interview with registered staff #110, indicated that the monthly MAR is circled every 72 hours identifying the dates the resident's medication is to be administered for the month. The staff member indicated that the MAR had been circled with the wrong starting date. The staff member indicated that at the time of administration, they did not have the previous MAR with them to check the last administration date.

The staff member indicated during an interview, that the physician was notified. Review of the resident's clinical record documentation, indicated that the physician had been made aware of the medication incident and orders were received. Documentation titled, Physician Notes Note, indicated that there were no concerns and they had been made aware of this medication incident and to continue current management.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 4 history of on-going non-compliance with this section of the O.Reg 79/10, that included:
-Voluntary Plan of Correction (VPC) issued October 21, 2016, (2016_248214_0023/030216-16),
-VPC issued October 24, 2017, (2017_689586_0007/024310-17). (214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 19th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Daria Trzos

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