Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 2, 2015	2015_205129_0019	H-003249-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE THOMAS HEALTH CARE CORPORATION
490 Highway #8 STONEY CREEK ON L8G 1G6

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

PINE VILLA NURSING HOME
490 HIGHWAY #8 STONEY CREEK ON L8G 1G6

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

PHYLLIS HILTZ-BONTJE (129), KELLY HAYES (583)

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): September 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 30 2015

Two additional inspections were completed concurrently with this Resident Quality Inspection - Complaint Inspection Log # H-003075-15 and Follow-up Inspection Log #H-002350-15 related to LTCHA s. 6(10)

During the course of the inspection, the inspector(s) spoke with residents, resident's family and substitute decision makers(SDM), Registered nurses (RN), Registered Practical Nurses (RPN), interim recreation manager and the Administrator/Director of Resident Care (Adm./DRC)
During the inspection inspectors reviewed clinical records (both paper copies and computerized records), documents created by the home, training records and the home's policies and procedures related to prevention and management of falls, minimizing retraining of residents, resident transfers and skin and wound management.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

12 WN(s)
4 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2015_240506_0004	129

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. 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 residents received, as a condition of continuing to have contact with residents training in the areas of; how to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations on an annual basis, in accordance with O. Reg. 79/10, s. 219(1), in relation to the following: [76(7)4]

A review of the homes in-service training attendance records and course completion records for how to minimize the restraining of residents and how to restrain in accordance with the Act and regulations was completed for 2014. The records showed 23 out of 46 direct care staff did not complete the "Restraints and PASD by Surge Learning" and 32 out of 46 direct care staff did not complete the "Least Restraint Training Presentation" course. In an interview with the Director of Resident Care on September 30, 2015, it was confirmed that all direct care staff did not receive skin and wound training in 2014 in accordance with the Act and regulations. [s. 76. (7) 4.]

2. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in accordance with O. Reg. 79/10, s.221(1)1 and 2 in the area of falls prevention and management and skin and wound care, in relation to the following: [76(7)6]

A review of the homes in-service training attendance records and course completion records for fall prevention management were completed for 2014. The records showed 36 out of 46 direct care staff did not complete the "How to Manage Risk and Prevent Injuries in Long-Term Care" and 23 out of 46 direct care staff did not complete the "Falls Prevention and Management Training" course. In an interview with the Director of Resident Care on September 30, 2015, it was confirmed that all direct care staff did not receive falls prevention and management training in 2014 in accordance with the Act and regulations.

A review of the homes in-service training attendance records and course completion records for skin and wound care were completed for 2014. The records showed 34 out of 46 direct care staff did not complete the "Pressure Ulcer Prevention: What Caring People Need to Know" and 32 out of 46 direct care staff did not complete the "Skin and Would Care Program for Front Line staff and Families" course. In an interview with the Director of Resident Care on September 30, 2015, it was confirmed that all direct care staff did not receive skin and wound training in 2014 in accordance with the Act and regulations. [s. 76. (7) 6.]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the direction contained in those documents was complied with, in relation to the following: [8(1) (b)
1. Staff did not comply with directions contained in the home's policy "Resident Client Falls" identified as # RC-09-02-10 and revised on November 1, 2011.This policy provided the following directions:
i) Registered staff to complete incident report, monthly resident incident summary form, and detailed progress notes.
ii) For the 48 hours following the fall, obtain vital signs every 8 hours.
iii) In case of an unwitnessed fall, perform neurological-vitals as per policy.

a) Staff and clinical documentation confirmed that on an identified date in 2015 resident #200 was found lying in a partially supine position on floor. Staff and clinical documentation confirmed that staff did not comply with the above noted directions when there was not documentation in the clinical record to indicate that the resident's vital signs were monitored every eight hours for the first 48 hours after the fall, that the resident was observed for possible injuries not evident at the time of the fall every eight hours after the fall and staff did not initiate monitoring the resident's neuro-vital signs after the unwitnessed fall.
(PLEASE NOTE: This non-compliance was identified while completing a complaint inspection Log #H-003075-15)

b) Staff and clinical documentation confirmed that on an identified date in 2015 resident #012 slid from their wheelchair and landed between the wheelchair footrests. The Adm./DRC confirmed that this incident would be considered a fall. Staff and clinical documentation confirmed that the directions contained in the above noted policy were not complied with when there was no documentation in the clinical record to indicate that the resident's vital signs were monitored every eight hours for the first 48 hours after the fall or that the resident was observed for possible injuries not evident at the time of the fall every eight hours after the fall.

c) A review of the Fall Incident Report completed on an identified date in 2015, indicated resident #004 was found to have had an unwitnessed fall from their bed. The progress notes completed for resident #004 did not contain documentation of a progress note of the fall, vitals-signs every eight hours for 48 hours after the fall or documentation of neurological-vitals as per the policy. In an interview with the Director of Resident Care on September 29, 2015, it was confirmed that the Resident Client Falls Policy was not

complied with following resident #004's fall. (583)

d) A review of the Fall Incident Report completed on an identified date in 2015, indicated resident #009 had a fall in their washroom while trying to transfer without staff assistance. The progress notes completed for resident #009 did not contain documented vitals-signs every eight hours for 48 hours after the fall as per the policy. In an interview with the Director of Resident Care on September 29, 2015, it was confirmed that the Resident Client Falls Policy was not complied with after resident #009's fall.(583)

2. Staff did not comply with directions contained in the home's "Wound/Skin Assessment" policy, identified as RC-04-10-07 and revised on March 1, 2017 in relation to the following:
This policy directed that "the Charge Nurse completes assessments at lease weekly, summarizing the stage, the size and depth, appearance of the wound base, discharge and appearance of surrounding tissue.
a) Staff and clinical documentation confirmed that staff did not comply with the above noted direction when it was identified on an identified date in 2015 that resident #007 had a wound and on the following day when it was identified that the resident had a second wound. Wound assessments completed on March 29, April 1, 8, 9, 15 and 22, 2015 did not consistently summarize the stage, size and depth, appearance of the wound bases, wound discharge or the appearance of surrounding tissue.

b) Staff and clinical documentation confirmed that staff did not comply with the above noted directions when wound assessments completed between April 29, 2015 and September 23, 2015 for resident #200 did not consistently summarized the stage, size and depth, appearance of the wound base, wound discharge or the appearance of the surrounding tissue for a wound that the resident had throughout this period of time. (PLEASE NOTE: This non-compliance was identified while completing a complaint inspection Log # H-003075-15)

3. Staff did not comply with directions contained in the home's "Turning and Positioning Record" identified as # RC-04-10-16 and revised on January 23, 2014, in relation to the following:
This policy directed that Personal Support Workers (PSWs) "initiate a Turning and Positioning Record (RC-05-06-30A) for all dependent residents and residents at risk for skin breakdown.
-Clinical documentation indicated that resident #007 was identified at high risk for skin

break down, had was identified as having two wounds and the resident's plan of care directed staff to turn and reposition the resident every two hours. Staff and clinical documentation confirmed that a Turning and Positioning Record had not been initiated for this resident.

4. Staff did not comply with directions contained in the home's "Guidelines in Restraint Use" identified as # RC-08-01-28 and revised on June 2, 2011.
This policy directed that restraining of a resident could only be done if there was a significant risk to the resident or another person, alternatives to restraints have been considered, method of restraining is reasonable, the physician or nurse in the extended class has ordered or approved the restraining and the restraining has been consented to by the resident or the substitute decision maker if the resident is incapable.
Staff and clinical documentation confirmed that resident #009's plan of care indicated that the resident used two half bed rails for safety that are included in the resident' s risk for falling care plan, the resident was capable of getting out of bed on their own and that the bed rails prevented the resident from leaving the bed. The above noted policy confirmed that in this situation the bed side rails would be considered a restraint. Staff did not comply with the above noted direction when registered staff and clinical documentation confirmed that there was not an assessment completed to identify the risk to the resident, alternatives to the use of the bed rails had not been considered, there were no orders for the use of the restrain and there was no documentation to indicate that the resident who is capable, provided consent to the use of bed side rails.

5. Staff did not comply with directions contained in the home's policy "Use of Bed Rails" identified as #RC-08-01-29B and revised on May 1, 2012
This policy directed that "Registered staff will assess the need for bed rails for each resident".
The Adm./DRC confirmed that this policy was not complied with when it was confirmed that the majority of the 40 residents in the home use bed rails and the home had not implemented a bed rail assessment process. [s. 8. (1) (b)]

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 failed to ensure that where bed rails were used the resident was assessed in accordance with evidenced based practices to minimize the risk to the resident in relation to the following: [15 (1)(a)]
Evidenced based practices have been identified by the Ministry of Health and Long Term care as those contained in the practise guidelines titled "Clinical Guidelines for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada)
A bed rail audit was conducted on September 30, 2015 and it was noted that 38 of the 41 beds were equipped with bed rails and at the time of the audit 16 of the 38 beds were noted to have bed rails raised in the active position.
The Administrator/Director of Resident Care confirmed the majority of residents in the home used bed rails, that the home had not implemented an assessment for the use of bed rails and the home was unaware of the evidenced base practice guidelines titled "Clinical Guidelines for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings 2003". [s. 15. (1) (a)]

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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the right of resident #200 to be cared for in a manner consistent with their needs was fully respected, in relation to the following: [3(1) 4]
Staff providing care to resident #200 on an identified date in 2015 did not respect the resident's right to be cared for in a manner consistent with their needs following a fall the resident sustained. Resident #200 sustained an unwitnessed fall from their wheelchair on the identified date, was found on the floor and at the time of the incident the resident was noted to have been incontinent of a large amount of feces. Staff, clinical documentation, family and documents provided by the home confirmed the following:
- Staff confirmed that at the time of the fall a mechanical lift was used to transfer the resident back into the wheelchair and the resident was moved from the to hallway outside their room. Staff and documents provided by the home confirmed that staff in attendance were aware that the resident required incontinence care and the resident's right to be cared for in a manner consistent with their needs was not respected, when this care was not provided for at least 30 minutes during which time the resident remained sitting in the wheelchair. Direct care staff confirmed that there were no events that occurred during the time following the resident's fall that would have prevented the resident from receiving care.
- Staff, family and documents provided by the home confirmed that when continence care was provided to the resident the resident's right to have care provided consistent with their needs was not respected. An hour after staff provided care to the resident, the resident was found with feces on their legs, buttocks and arms, the resident's bedding was found to be soiled with feces and the resident's wheelchair was left unclean and soiled with feces.
-An assessment of resident #002 was completed based on the resident's needs that included a medical condition that affected the resident's mobility, unsteady gait, numerous falls, decreased general strength and a visual impairment. The results of that assessment concluded that in order to be safe the care needs of the resident were identified as requiring two staff to provide total assistance to toilet, two staff were to provide extensive assistance with transfers and these care directions where included in

the resident's plan of care. Staff and documents provided by the home confirmed that the resident's right to be cared for in a manner consistent with their needs was not respected when following the identified fall incident a staff person providing care to the resident placed the resident at risk when they did not get the assistance of another staff to toilet the resident, to transfer the resident from the toilet into the wheelchair and to transfer the resident from the wheelchair into bed in accordance with the resident's assessed care needs.
-Following the unwitnessed fall resident #200 required ongoing monitoring to identify and treat any injuries that may have occurred as a result of the fall. The home's policies and procedures identified that for any resident who has fallen staff are expected to monitor a variety of indicators over specific periods of time in order to identify and treat any possible injuries that may have occurred as a result of falling. Staff and clinical documentation confirmed that resident #200's right to be cared for in a manner consistent with their needs was not respected when staff did not monitor the resident following the identified fall in order to determine if the resident had suffered any injures from the unwitnessed fall.
(PLEASE NOTE: This non-compliance was identified while completing a complaint inspection Log #H-003075-15) [s. 3. (1) 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 and ensuring that the right of residents to be cared for in a manner consistent with their needs 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. 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 the written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident, in relation to the following: [6(1) (c)]
a) The plan of care for resident #009 did not provide clear directions for staff related to the use of a front fastening seat belt while the resident was sitting in a wheelchair. Resident #009 was observed to have a front fastening seat belt applied when they were sitting in the wheelchair. The resident was interview on September 24, 2015 and the resident demonstrated that they were able to release the seat belt; the resident however, was not able to apply the seat belt due to a medical condition that affected their mobility. Staff confirmed that they applied the seat belt and also confirmed the document that direct care staff use to identify the care required by the resident was the care plan and this document was kept in a binder in the nursing station area. Staff and clinical

documentation confirmed that the care plan did not provided clear direction to staff regarding when the seat belt should be applied or the reason the seat belt is being used for this resident.

b) The plan of care for resident #200 did not provide clear direction to staff related to skin and wound and the use of foot wear.
Staff and clinical documentation confirmed that resident #200's plan of care contained conflicting and unclear information and directions, in the following areas:
-Different parts of the plan of care provided conflicting information related to skin and wound care. The plan of care identified the resident currently had a wound, was at risk for developing wounds but currently did not have any wounds and had a second identified wound on another part of the body.
-The plan of care provided conflicting information and unclear direction in relation to foot wear. The plan of care identified family had requested that no shoe or slipper be put on the resident's right foot, the resident was on a walking program and staff were to ensure the resident wears proper and non-slip footwear and staff were to check that shoes are not tight or rubbing.
-The plan of care provided unclear direction related the type of foot protection the resident was to wear on the right foot. The plan of care identified that staff were to "ensure the resident was to wear a bootie under identified circumstances". At the time of the inspection the resident was noted to be wearing two different devices that staff referred to as "a bootie". The plan of care did not provide clear directions to staff providing care related to which bootie the plan of care was referring to or when the staff should apply either bootie the resident was noted to be wearing during the inspection.
(PLEASE NOTE: This non-compliance was identified while completing a complaint inspection Log #H-003075-15)

c) The plan of care for resident #007 did not provide clear direction to staff related to skin and wound care.
Staff and clinical documentation confirmed that the plan of care did not provide clear direction to staff in relation to wearing a protective device. The Wound Assessment and Treatment Evaluation Plan dated March 29, 2015 directed that an intervention for the management of wounds was to wear a protective device. The resident's plan of care did not contain information that the identified device was to be worn to manage an identified wound and to promote healing.

d)The plan of care for resident #012 provided conflicting and unclear direction for staff related to positioning.

Care plan interventions in the "Physical Restraint" section directed staff that while in the wheelchair staff were to check and change the resident's position every hour, in the "Mobility/Ambulation" section staff were directed to turn and reposition the resident every two hours, in the "Falls" section staff are directed to check the resident and reposition the resident every hour and in the second "Physical Restraint" section staff were to check the resident every hour and reposition the resident every two hours. [s. 6. (1) (c)]

2. The licensee failed to ensure that resident #012's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care, in relation to the following: [6(5)]
Resident #012's substitute decision-maker (SDM) confirmed that they were not given the opportunity to participate in the development of the resident's plan of care related to a concern for ongoing falls, when staff did not inform them of a fall the resident experienced on an identified date. The SDM confirmed that a co-resident's visitor informed them that the resident was sitting in their wheelchair and the visitor witnessed the resident slide out of their wheelchair and land between the wheelchair footrests. The co-resident's visitor communicated this to resident #012's SDM because they were concerned that the resident injured themselves while making contact with the hard edges of the wheelchair footrests. At the time of this inspection resident #012's SDM confirmed that they were concerned when the visitor told them about the fall because the resident could have injured themselves, the visitor indicated that staff transferred the resident into the wheelchair without checking to see if the resident was injured and the resident had been ordered to have a seat belt applied when sitting in the wheelchair as an intervention to prevent falling. The SDM confirmed that staff did not notify them of the fall, did not discuss with them proposed changes to the resident's plan of care to prevent a re occurrence and did not explain how the resident could slide from the chair with a seat belt applied. [s. 6. (5)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care, in relation to the following: [6(7)]
1. Staff did not ensure that resident #200 was provided with care as specified in their plan of care in relation to the use of a chair alarm. Resident #200 fell on an identified date in 2015 and was found by staff lying on the floor. Staff and clinical documentation confirmed that the plan of care for this resident directed that the resident had a chair alarm and staff were to ensure that the alarm was on and working whenever the resident is in the wheelchair, as an intervention to manage a high risk for falling. Investigative notes written and compiled by the Administrator/Director of Resident Care (Adm./DRC) confirmed that at the time of this fall the chair alarm had not been put in place on the

resident's wheelchair.
2.Staff did not ensure that resident #200 was provided with care as specified in their plan of care in relation to transfers and toileting. Staff and clinical documentation confirmed that the plan of care for this resident directed that the resident required total assistance of two staff for toileting related to an unsteady gait and a medical condition that effected their mobility and also indicated that the resident required extensive assistance of two staff for transfers from one position to another due to a decrease in strength and a visual impairment. Investigative notes written and compiled by the Adm./DRC and staff involved in the incident confirmed that following a fall on the identified date the resident was not provided with the care as specified in the plan of care when the resident was assisted to the toilet by one PSW and the resident was transferred from the wheelchair to the bed with the assistance of one PSW.
(PLEASE NOTE: This non-compliance was identified while completing a complaint inspection Log #H-003075-15) [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective, in relation to the following: [6(10)(c)]
1. Staff and clinical documentation confirmed that resident #012 had a plan of care focus related to a high risk for falling and the goal of care planned to manage this risk was identified as "No falls fall related injuries". Clinical documentation indicated that on an identified date in 2015 the resident slid from their wheelchair and landed between the wheelchair footrests. Staff confirmed that the resident's plan of care was not reviewed or revised following this fall and all existing care interventions remained in place even though the care to manage this risk had not been effective.
2. A review of the plan of care for resident #004 identified they were at high risk of falls and had a fall on an identified date in 2015, from their bed and on a second identified date, from their wheel chair. Resident #004's fall care plan goal was to have no falls. A review of the plan of care for resident #004 identified that no changes were made to the interventions that were in place in the falls care plan after the above mentioned falls. In an interview with the Director of Resident Care on September 25, 2015, it was confirmed that the plan of care was not revised when the falls interventions set out in the plan of care were not effective in preventing falls for resident #004. (583)
3. A review of the plan of care for resident #009 identified they were at risk for falls and had a fall on an identified date in 2015, while trying to transfer without assistance. Resident #009's fall care plan goal was to have no falls. A review of the plan of care for resident #009 identified that no changes were made to the interventions that were in place in the falls care plan after the identified fall. In an interview with the Director of

Resident Care on September 25, 2015, it was confirmed that the plan of care was not revised when the falls interventions set out in the plan of care were not effective in preventing falls for resident #009. (583) [s. 6. (10) (c)]

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 and ensuring that staff comply with the requirements identified in LTCHA 2007, c. 8, s. 6(1)c, 6(5), 6(7)and 6(10)c, to be implemented voluntarily.

WN #6: 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. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by a physical device was included in the residents plan of care only if the plan of care met the requirements identified in the LTCHA, 2007, S.O., c. 8, s 31(2) prior to applying a physical device that restrained the resident, in relation to the following: [31(1)]
a)Staff confirmed that resident #009 was restrained by the use of a physical device when it was identified by staff that two half bed rails were applied whenever the resident was in bed, the resident was not able to lower the bed rails, the resident was capable of getting out of bed, the bed rails prevented the resident from leaving the bed and the use of bed rails was included in the resident's plan of care as an intervention related to a risk for falling. Staff confirmed that an assessment was not completed that identified the risk the resident or another person would suffer if the resident #009 was not restrained, staff did not consider alternatives to the use of the bed rails, a physician or registered nurse in the extended class had not ordered or approved the use of the bed rails and the use of the bed rails had not been consented to by resident #009 who was identified as capable of making care decisions.

b) A review of resident #010's plan of care identified they had two half bed rails in the up position while in bed. The care plan identified they were used as an intervention for falls. In an interview with Registered Practical Nurse (RPN) and the Personal Support Workers (PSW)s on September 23, 2015, it was shared that resident #010 was able to get out of bed on their own and that the bed rails prevented the resident from getting out of bed. A PSW who worked night shift identified resident #010 demonstrated a responsive behaviour that increased the risk of falling from bed.
In an interview with the Director of Resident Care on September 25, 2015, it was confirmed that the bed rails being used for resident #010 were a restraint. It was confirmed that an assessment was not completed that identified the risk to the resident or another person if resident #010 was not restrained, staff did not consider alternatives to the use of bed rails, a physician or registered nurse in the extended class had not ordered or approved the use of the bed rails and the use of the bed rails had not been consented to by the substitute decision-maker or resident #010. (583) [s. 31. (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 and ensuring that all the requirements are met prior to applying a physical device used to retrain a resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that staff applied a physical device in accordance with any manufactures directions, in relation to the following: [110(1) 1]
Manufactures directions for the application of seat belts provided by the home stated that the belt was "not to be applied too tightly or too loosely". The Administrator/Director of Resident Care (Adm./DRC) confirmed that is was the expectation that a seat belt was to be applied to allow for a two finger space between the seat belt and the resident's body.
1. Staff did not apply a seat belt being used to restrain resident #200 in a wheelchair in accordance with the manufactures directions and the expectations of the home. Resident #200 was observed on an identified date to be sitting in the front lounge area while an exercise program was in progress. The resident was noted to have a side fastening clip type seat belt applied and the seat belt had been applied so tightly that it was applying significant pressure on the resident's abdomen. At the time of this observation the resident confirmed that the seat belt was not comfortable and was too tight. The resident's plan of care confirmed that the seat belt was being used to restrain the resident while sitting in the wheelchair as an intervention to manage a high risk of falling. A PSW who reapplied the seat belt following the above noted observation confirmed that the seat belt had been reapplied because it was found to be applied too tightly. (PLEASE NOTE:This non-compliance was identified while completing a complaint inspection Log # H-002350-15)
2 Staff did not apply a seat belt being used to restrain resident #202 in a wheelchair in accordance with the manufactures directions and the expectations of the home. Resident #202 was noted to be sitting in the front lounge area on an identified date with a front fastening seat belt applied and it was noted that there was a four inch gap between the resident's body and the seat belt. The resident's plan of care confirmed that the seat belt was being used to restrain the resident while sitting in the wheelchair as an intervention to manage a risk of falling. At the time of the above noted observation a PSW confirmed that the seat belt had been applied too loosely and reapplied the seat belt. [s. 110. (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 and ensuring that when a physical device is used to restrain a resident the device is applied in accordance with any manufactures directions, to be implemented voluntarily.

WN #8: 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:
1. Customary routines. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of residents' customary routines, in relation to the following:[26(3)1]

During an observation of resident # 001, #010 and #300 on September 21 and 24, 2015, they were noted to have hair on their upper lip and chin greater than three millimeters in length. A review of the plan of care for resident # 001, #010, and #300 identified they required extensive assistance for grooming and did not identify the resident's preference, frequency and method used for facial hair removal. In an interview with the Registered Practical Nurse (RPN) and the Personal Support Workers (PSWs) on September 24, 2015, it was shared that the plan of care did not provided direction for the resident's grooming routines. In an interview with the Director of Resident Care on September 25, 2015, it was confirmed there was not an interdisciplinary assessment of resident #001's, #010's and #300's customary routines. [s. 26. (3) 1.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program including interventions and the resident's response to interventions are documented, in relation to the following: [30(2)]
1. Staff in the home did not ensure that actions taken with respect to the program for minimizing the restraining of residents were document.
Staff and the clinical documentation confirmed that resident #009 had two half bed rails raised whenever they are in bed, they are able to get out of bed and the bed rails prevent the resident from leaving the bed. The resident's plan of care identified the use of bed rails as an intervention to manage the risk of falling. Staff and clinical documentation confirmed there was no documentation to confirm that the resident was monitored every hour when they were in bed with the bed rails in the active position. [s. 30. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received individualized personal care, including grooming, on a daily basis, in relation to the following: [32]

During an observation of resident #010 on September 21, 2015, they were noted to have hair on their upper lip and chin greater than three millimeters in length. During an interview with resident #010's family on September 21, 2015, it was shared that their expectation was that resident #010 would have their facial hair removed daily. During an observation on September 24, 2015, resident #010 was observed to have facial hair growth on their chin. In an interview with the registered and non-registered nursing staff it was confirmed that resident #010's facial grooming had not been completed on September 24, 2015, and that it was routinely not being completed on a daily basis. [s. 32.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post fall assessment was conducted, in relation to the following: [49(2)]
Staff, clinical documentation and a visitor who witnessed the fall confirmed that resident #012 was in the front lounge area on an identified date sitting in a wheelchair and was noted to slide from the wheelchair and land between the footrests of the wheelchair. The Administrator/Director of Resident Care (Adm./DRC) confirmed that this incident would be considered a fall. Staff, clinical documentation and a visitor who witnessed the fall confirmed that the resident was not assessed at the time of the fall and there was not a post fall assessment completed related to this incident. [s. 49. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the process to report and locate residents' lost clothing and personal items was implemented, in relation to the following: [89(1)(a)(iv)]

During interviews with resident #011, #015, and #012's family it was identified these residents had missing clothing or personal items, which they reported to staff that had not been located. A review of the "Lost Clothing and Personal Items" policy (RC-04-09-30), effective September 12, 2012, identified the home had a process to report and locate lost clothing and personal items. In an interview with registered and non-registered nursing staff it was identified that the staff were not familiar with the "Lost Clothing and Personal Items" procedure and that the home was not using the "Lost Clothing Tracking Sheet" as directed in the procedure. It was shared that a consistent process was not being used to report and locate residents' lost clothing. In an interview with the Administrator on September 22, 2015, it was confirmed that the procedure to report and locate residents' lost clothing was not implemented. [s. 89. (1) (a) (iv)]

Issued on this 26th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2015_205129_0019
Log No. / Registre no:	H-003249-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 2, 2015
Licensee / Titulaire de permis :	THE THOMAS HEALTH CARE CORPORATION 490 Highway #8, STONEY CREEK, ON, L8G-1G6
LTC Home / Foyer de SLD :	PINE VILLA NURSING HOME 490 HIGHWAY #8, STONEY CREEK, ON, L8G-1G6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paula White

To THE THOMAS HEALTH CARE CORPORATION, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
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.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to 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 of minimizing the restraining of residents, falls prevention and management as well as skin and wound care annually, in accordance with O. Reg. 79/10, s. 219(1).

The plan shall include but is not limited to:

1. The development and implementation of an annual training schedule related to the above mentioned mandatory training.
2. The development and implementation of a mechanism to monitor staffs participation in the mandatory training sessions.
3. The development and implementation of a process that will be followed, when the above noted monitoring mechanism identifies that not all staff have attended the mandatory training to ensure that all staff required to, have received the training within the annual period of time.
4. The development and implementation of an annual review of the training and orientation program that monitors the effective of training provided in the home.

The plan is to be submitted to Phyllis Hiltz-Bontje by email at Phyllis.Hiltzbontje@Ontario.ca, on or before November 16, 2015.

Grounds / Motifs :

1. All staff providing direct care to residents did not receive annual mandatory training in 2015 for three of three programs reviewed.

2. A review of the homes in-service training attendance records and course completion records for the area of minimize the restraining of residents and how to restrain in accordance with the Act and regulations was completed for 2014. The records showed 23 out of 46 direct care staff did not complete the "Restraints and PASD training by Surge Learning" and 32 out of 46 direct care staff did not complete the "Least Restraint Training Presentation" course. In an interview with the Director of Resident Care on September 30, 2015, it was confirmed that all direct care staff did not receive skin and wound training in 2014 in accordance with the Act and regulations. (583)

3. A review of the homes in-service training attendance records and course completion records for the area of fall prevention management were completed for 2014. The records showed 36 out of 46 direct care staff did not complete the "How to Manage Risk and Prevent Injuries in Long-Term Care" and 23 out of 46 direct care staff did not complete the "Falls Prevention and Management Training" course. In an interview with the Director of Resident Care on September 30, 2015, it was confirmed that all direct care staff did not receive falls prevention and management training in 2014 in accordance with the Act and regulations. (583)

4. A review of the homes in-service training attendance records and course completion records for the area of skin and wound care were completed for 2014. The records showed 34 out of 46 direct care staff did not complete the "Pressure Ulcer Prevention: What Caring People Need to Know" and 32 out of 46 direct care staff did not complete the "Skin and Would Care Program for Front Line staff and Families" course. In an interview with the Director of Resident Care on September 30, 2015, it was confirmed that all direct care staff did not receive skin and wound training in 2014 in accordance with the Act and regulations. (583) (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff comply with the home's policies, procedures and protocols including those related to Falls Prevention and Management, Skin and Wound Care, Minimizing the Restraining of Residents, Use of Bed Rails and Resident Transfers.
The plan shall include, but is not limited to:
1. The development and implementation of a review and where required revision process for the above noted policies, procedures and protocols to ensure they are updated, consistent with the requirements in the LTCH Act and Regulations, consistent with the changing practices in the home and provide clear directions to staff.
2. The development and implementation of a training program for staff related to the above mentioned policies, procedures and protocols following the above noted review/revision process.
3. The development and implementation of a schedule for monitoring staffs performance in complying with the above mentioned policies, procedures and protocols.

The plan is to be submitted to Phyllis Hiltz-Bontje, by email at Phyllis.Hiltzbontje@Ontario.ca on or before November 16, 2015.

Grounds / Motifs :

1. Previously identified non-complaint on December 5, 2012 as a WN and on February 23, 2015 as a VPN.

2. Staff did not comply with five of five policies, procedures and protocols reviewed that comprise the directions to staff in the areas of Falls Prevention and Management, Skin and Wound Care, Minimizing the Restraining of Residents, Resident Transfers and Use of Bed Rails.
3. Staff did not comply with directions contained in the home's "Wound/Skin Assessment" policy, identified as RC-04-10-07, revised on March 1, 2017 in relation to the following:
This policy directed that "the Charge Nurse completes assessments at lease weekly, summarizing the stage, the size and depth, appearance of the wound base, discharge and appearance of surrounding tissue.
-Staff and clinical documentation confirmed that staff did not comply with the above noted direction when on an identified date in 2015 it was noted that resident #007 had a wound and the following day it was noted that the resident had a second wound. Wound assessments completed on March 29, April 1, 8, 9, 15 and 22, 2015 did not consistently summarize the stage, size and depth, appearance of the wound bases, wound discharge or the appearance of surrounding tissue.
-Staff and clinical documentation confirmed that staff did not comply with the above noted directions when wound assessments completed between April 29, 2015 and September 23, 2015 for resident #200 did not consistently summarized the stage, size and depth, appearance of the wound base, wound discharge or the appearance of the surrounding tissue for a wound this resident was identified has having throughout this period of time.
4. Staff did not comply with directions contained in the home's "Turning and Positioning Record" identified as # RC-04-10-16 and revised on January 23, 2014, in relation to the following:
This policy directed that Personal Support Workers (PSWs) "initiate a Turning and Positioning Record (RC-05-06-30A) for all dependent residents and residents at risk for skin breakdown.
-Clinical documentation indicated that resident #007 was identified at high risk for skin break down, had wounds and the resident's care plan directed staff to turn and reposition the resident every two hours. Staff and clinical documentation confirmed that a Turning and Positioning Record had not been initiated for this resident.
5. Staff did not comply with directions contained in the home's "Guidelines in Restraint Use" identified as # RC-08-01-28 and revised on June 2, 2011.
This policy directed that restraining of a resident could only be done if there was a significant risk to the resident or another person, alternatives to restraints have been considered, method of restraining is reasonable, the physician or nurse in

the extended class has ordered or approved the restraining and the restraining has been consented to by the resident or the substitute decision maker if the resident is incapable.
Staff and clinical documentation confirmed that resident #009's plan of care indicated that the resident used two half bed rails for safety that were included in the resident' s risk for falling care plan, the resident was capable of getting out of bed on their own and that the bed rails prevent the resident from leaving the bed. The above noted policy confirmed that in this situation the bed side rails would be considered a restraint. Staff did not comply with the above noted direction when registered staff and clinical documentation confirmed that there was not an assessment completed to identify the risk to the resident, alternatives to the use of the bed rails had not been considered, there were no orders for the use of the restrain and there was no documentation to indicate that the resident who is capable, provided consent to the use of bed side rails.
6. Staff did not comply with directions contained in the home's policy "Resident Client Falls" identified as # RC-09-02-10 and revised on November 1, 2011. This policy directed that
i) in the event of a fall "for the first 48hours following the fall staff were to obtain vital signs every 8 hours, observe for possible injuries not evident at the time of the fall (limb reflex, joint range of motion, weight bearing, etc.), monitor mental status, document in the resident's progress notes every shift and if the fall was unwitnessed staff were to perform neuro-vitals as per the home' policy.
ii) registered staff to complete incident report, monthly resident incident summary form, and detailed progress notes.
a) Staff and clinical documentation confirmed that on an identified date resident #200 was found lying in supine position on floor. Staff and clinical documentation confirmed that staff did not comply with the above noted directions when there was not documentation in the clinical record to indicate that the resident's vital signs were monitored every eight hours for the first 48 hours after the fall, that the resident was observed for possible injuries not evident at the time of the fall every eight hours after the fall and staff did not initiate monitoring the resident's neuro-vital signs after the unwitnessed fall.
b) Staff and clinical documentation confirmed that on an identified date resident #012 slid from their wheelchair and landed on the foot rests. The Administrator/Director of Resident Care (DRC) confirmed that this would be considered a fall. Staff and clinical documentation confirmed that the directions contained in the above noted policy were not complied with and a post fall assessment was not documentation in the clinical record to indicate that the resident's vital signs were monitored every eight hours for the first 48 hours after

the fall or that the resident was observed for possible injuries not evident at the time of the fall every eight hours after the fall.
c) A review of the Fall Incident Report completed on an identified date, indicated resident #004 was found to have had an unwitnessed fall from their bed. The progress notes completed for resident #004 from the day of the fall including three days after the fall, did not contain documentation of a progress note of the fall, vitals-signs every eight hours for 48 hours after the fall or documentation of neuro-vitals as per the policy. In an interview with the Director of Resident Care on September 29, 2015, it was confirmed that the Resident Client Falls Policy was not complied with after resident #004's fall. (583)
d) A review of the Fall Incident Report completed on an identified date, indicated resident #009 had a fall while trying to transfer without staff assistance. The progress notes completed for resident #009 from the day of the fall including three days after the fall, did not contain documented vitals-signs every eight hours for 48 hours after the fall as per the policy. In an interview with the Director of Resident Care on September 29, 2015, it was confirmed that the Resident Client Falls Policy was not complied with after resident #009's fall. (583)
7. Staff did not comply with directions contained in the home's policy "Use of Bed Rails" identified as #RC-08-01-29B and revised on May 1, 2012
This policy directed that "Registered staff will assess the need for bed rails for each resident".
The Admin./DRC confirmed that this policy was not complied with when it was confirmed that the majority of the 40 residents in the home use bed rails and the home has not implemented a bed rail assessment process. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

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 : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall assess all residents who currently use bed rails in accordance with evidence–based practices.

Grounds / Motifs :

1. A bed rail audit was conducted on September 30, 2015 and it was noted that 38 of the 41 beds were equipped with bed rails and at the time of the audit 16 of the 38 beds were noted to have bed rails raised in the active position. The Administrator/Director of Resident Care confirmed the majority of residents in the home used bed rails, that the home had not implemented an assessment for the use of bed rails and the home was unaware of the evidenced base practice guidelines titled "Clinical Guidelines for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings 2003". (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 2nd day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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