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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 02, 2018;	2017_561583_0018 (A2)	023282-17	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Tullamore Care Community
133 KENNEDY ROAD SOUTH BRAMPTON ON L6W 3G3

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

KELLY HAYES (583) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

WN #11 related to O.Reg 79/10, s. 221 was rescinded.

Issued on this 2 day of February 2018 (A1)

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

Original report signed by the inspector.

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KELLY HAYES (583) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 5, 6, 9, 10, 11, 12, 13, 16, 17 and 18, 2017.

During the course of this inspection, the following additional inspections were conducted:

Follow Up Inspections: Log #009353-17, related to skin and wounds; log #009355 -17 and #009356-17, related to medications; log #009357-17, related to responsive behaviours; and log #009359-17, related to the prevention of abuse and neglect.

Critical Incident System (CIS) Inspections: Log #004649-17, related to alleged abuse; log #019638-17 and #00783-17, related to resident to resident physical altercations, and log #022754-17 and #023986-17, related to alleged staff to resident abuse.

Complaint Inspections: Log #009937-16, related to personal support services; log #007144-17, #010954-17, #00986-17 and #010272-17 related to infection control, accommodation services and personal support services; and log #004649-17, related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC) #001 and #002, Social Worker, Registered Dietitian (RD), Physio Therapist (PT), Food Services Supervisor (FSS), Director of Dietary Services, Behavioural Support Ontario (BSO) Champion, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), families and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, menus and clinical health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (5)	CO #002	2017_546585_0003	561
O.Reg 79/10 s. 229. (6)	CO #003	2017_546585_0003	561
O.Reg 79/10 s. 50. (2)	CO #001	2017_546585_0003	561
O.Reg 79/10 s. 55.	CO #002	2017_546585_0004	583

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. 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 :

(A1)
1. The licensee did not ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

The home was equipped with mattresses from different manufacturers. According to two of the manufacturer's, the pressure was to be set to the maximum setting prior to cleaning and before and after getting into and out of bed and the pressure re-set to the resident's weight and comfort preferences once the resident was lying on the mattress.

The home's policy titled "Skin and Wound Care Management Protocol" dated April 2016, included direction for registered staff to determine the setting of specific mattresses by using the weight chart as per manufacturer's instructions to maintain a setting that was comfortable for the resident. No additional information was included to determine comfort for a resident who could not communicate other than to slide a hand under their body to ensure the deck of the bed could not be felt. No information was included about who was required to inspect the mattresses, how often or how they were to be cleaned. The setting parameters and frequency of safety checks were to be documented on the resident's care plan and the

information included on the "resident list on the RHA tracking tool".

Three residents (see below) were observed to be lying on a specific surface in 2017. All three residents' written plan of care included the statement "Ensure specific mattress is in the range at all times". The statement did not provide any useful information for staff who provide care about specific pressure settings or comfort level.

i) Resident #101 had a specific mattress. When the unit was observed in October 2017, the pressure setting was set at 16 Kilograms (Kg) less than required for resident #101.

ii) Resident #090 had a specific mattress. When observed in October, 2017, the power supply unit was sitting on their mattress (instead of hanging off the foot board) and the pressure setting was set to the highest setting. After asking several nursing staff to verify the settings, none were able to do so at the time. The pressure setting was confirmed to be set approximately 160 Kg more than required.

iii) Resident #120 had a specific mattress. When observed when the resident was in bed in October 2017, the pressure setting was set at 35 Kg more than required.

The licensee therefore did not ensure that staff were aware of the various manufacturers' requirements for the comfort and pressure settings for the various types of specific mattresses for each resident by setting out clear directions in the written plan of care. [s. 6. (1) (c)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any time when the goal is met, the care set needs changed or the care set out in the plan was no longer necessary or when the care set out in the plan was not effective.

A) A review of resident #043's interdisciplinary care conference notes, identified they were at high nutrition risk, and required nutrition interventions due to their medical conditions.

During a lunch observation in October 2017, resident #043 was on a regular texture diet and was served their meal but their nutrition intervention was not provided. An interview was completed with the two cooks working in the kitchen

and they shared they did not provide the resident the intervention as the resident usually didn't take it. They shared the resident was having difficulty with their diet texture. During the lunch service observation resident #043 did not eat well and in an interview with the resident they identified they were having difficulty with their diet texture.

In an interview with the DOC and ADOC on October 18, 2017, it was confirmed that resident #043 was not reassessed and the nutrition plan of care was not updated when it was identified the residents diet texture care needs changed and when it was identified the intervention had not been effective. (583)

B) Resident #007 who was assessed to be high risk for falls was observed by staff to have a fall on an identified date in 2017.

A falls incident-post fall huddle was completed, which included immediate action taken but did not identify any changes required to the plan of care. The Physiotherapist (PT) assessment documented at the same time as the post fall huddle, provided fall risk reduction recommendations with specific interventions for the resident.

A review of the falls care plan showed no revisions were made after the fall nor had any been made over a one year period. The plan of care was not revised to include the PT's recommendations and did not identify strategies for fall monitoring. In an interview with ADOC #001 it was confirmed that resident #007's falls plan of care was not revised when the resident's needs changed. (583)

C) Resident #055 had a plan of care indicating that they were frequently incontinent of bladder and bowel. Health care records were reviewed and indicated that the resident had a significant change of health condition and their continence had deteriorated. Resident was not reassessed and the plan of care was not revised at that time.

RN #302 confirmed that resident had a change in continence and was now frequently incontinent of bladder and bowel and required to wear incontinent product. The current written plan of care was reviewed and indicated that resident was not wearing any incontinent products and the change of continence was not documented in the written plan of care.

In an interview with the RN #302 indicated that the expectation of staff was to reassess the resident when they had a deterioration in continence and the plan of care should have been revised to reflect the change.

The licensee failed to ensure that resident was reassessed the plan of care reviewed and revised when the resident's needs changed. (561)

D) Resident #077 had a significant change in health condition which required an intervention while in the hospital in 2017. Prior to hospitalization resident was incontinent of bowel and bladder according to the Minimum Data SET (MDS) quarterly assessment. The MDS significant change in condition assessment indicated resident was incontinent of bowel and coded as continent of bladder.

The health care records revealed that resident was not reassessed when they had the change in continence. RN #302 confirmed that the resident was not reassessed using the bladder and bowel assessment tool in Point Click Care (PCC) when they had a change in continence.

Furthermore, when resident returned from the hospital with a medial intervention related to continence care staff did not obtain an order for the intervention from the physician. A note was added to the doctor book; however, the order was never obtained. The Treatment Administration Record (TAR) and Medication Administration Record (MAR) were reviewed and the order for the intervention could not be found. RN #302 was interviewed and indicated that an order for the intervention should have been obtained when resident returned from the hospital.

The licensee failed to ensure that resident was reassessed when they had a significant change in condition which required a medical intervention. (561)

E) Resident #013's health care record was reviewed and the written plan of care identified the resident to be on specified precautions related to their medical condition. Resident 013's room was observed and the precautions signage was present on the door. The Infection Control Surveillance Record for October was reviewed and the resident was not added to the surveillance. Further review of health care record revealed that resident was on precautions on an identified date in 2017 and had treatment for a medical condition and it was now completed. Resident was currently free from infections. The DOC indicated that resident was no longer symptomatic and was not on precautions. The DOC confirmed that the written plan of care was not revised when the resident completed their treatment

and no longer required precautions.

The licensee failed to ensure that resident's written plan of care was revised when the care needs changed. (561)

F) Resident #071 had a plan of care indicating that they were at high risk for falls and was a frequent faller. The health care records were reviewed and revealed that resident sustained 10 falls over a three month period in 2017. All these falls resulted from resident attempting to self transfer from various locations. Most falls also occurred during identified times. The progress notes were reviewed and the Physiotherapist completed assessments of the resident post fall and recommended a number of interventions.

The Physiotherapist was interviewed in October 2017 and confirmed that they had recommended these interventions; however it was the nursing department expectation to review the recommendations and decide whether they would be appropriate for the resident and the registered staff would then revise the care plans to reflect current needs of the resident. PSW #203 who provided direct care to the resident indicated that resident was at high risk for falls and shared what falls prevention interventions were being provided; however, PSW #203 indicated a number of the interventions were no longer effective that were in the falls care plan. The staff shared new interventions that they were providing. The written plan of care was not revised when these interventions changed.

The RN #300 was interviewed and confirmed that the written plan of care was not revised with the recommendation made by the Physiotherapist. The ED was interviewed and confirmed that there was a gap between the recommendations made by the physiotherapist and the nursing department and the plan of care was not revised with the falls interventions.

The licensee failed to ensure that the plan of care was revised when the care needs changed for this resident in relation to falls. (561)

G) The Registered Dietitian (RD) was sent three referrals for resident #028 for altered skin integrity on identified dates in 2017 over a two month period.

The resident was assessed as having an area of altered skin integrity that showed no signs of improvement over a three month period in 2017, since the area was initially identified.

During the first assessment completed when the altered skin integrity was identified, the RD added a dietary intervention at breakfast to increase the protein content of resident #028's diet.

During the second and third assessment, completed by the RD no changes were made to resident #028's nutrition interventions or plan of care.

In an interview with the RD in October 2017, it was confirmed that resident #028, would need to eat 100% of their meals and special intervention daily to meet their protein requirements and that the resident's intake was often less consuming anywhere from 50 to 100 %. It was confirmed resident #028, still had altered skin integrity with no improvement. It was confirmed that the resident's current diet may not also meet the residents protein requirements and that no new interventions to increase the protein content of the diet were added when the resident's skin integrity had not improved. (583) [s. 6. (10)]

Additional Required Actions:

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

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

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 there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that a resident was neglected by the licensee or staff.

A) For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On an identified date in 2017, resident #043 had a fall. The post fall huddles assessment identified the resident's had a medical incident related to a known medical condition that contributed to the fall. The resident was monitored and treated but the condition was not treated according to the homes policies. A note was left in the doctor's book for the physician to reassess the resident's condition on their next scheduled visit. The physician was notified at the time of the incident.

At the time of the fall the resident's medical condition was being monitored twice a week.

The next day when the resident was being monitored the resident had another incident related to their medical condition. There was no documentation of what action was taken and the physician was not notified. In an interview with the RD in October 2017, it was confirmed they did not receive a referral for resident #043's two incidents related to their medical condition.

In an interview with ADOC #001 and the DOC on October 18, 2017, it was confirmed that there was a pattern of inaction by the home of the management of resident #043's two medical events and that the pattern of inaction put the resident at further risk of having another event. It was confirmed that the definition of "neglect" meaning the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health, safety or well-being was identified.

B) The licensee failed to ensure that residents were protected from abuse by anyone.

For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

A review of resident #088 care plan identified they had known verbal and physical responsive behaviours towards other residents, related to environmental triggers. Resident #088 was independent with mobility with the used a mobility aid. They were observed throughout the inspection in areas where known environmental triggers were present.

In an interview with the DOC, ADOC #001 and BSO Champion it was shared in the homes environment that resident #088's triggers for responsive behaviours were difficult to avoid and the resident could not always be monitored. Three incidents occurred in 2017, when effective interventions were not provided for resident #088's responsive behaviours.

On an identified date in 2017, staff where notified by resident #132 that resident #088 demonstrate a responsive behaviour towards them causing injury.

On a second identified date in 2017, staff observed resident #088 demonstrate responsive behaviours towards resident #017 causing an injury.

On a third identified date in 2017, staff observed resident #088 demonstrate responsive behaviours towards resident #131 causing an injury.

In addition to the physical responsive behaviours which caused injury there were a number of additional incidents where resident #088 demonstrated responsive behaviours that had potential to harm other residents.

In an interview with the DOC and ADOC in October 2017, it was confirmed that resident #132, #017 and #131 were not protected from abuse by resident #088 who had known physical responsive behaviours with previously identified triggers. [s. 19.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

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 :

(A1)
1. The licensee did not ensure that, where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the residents.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document

includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". These are the “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" and “A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006”, and are considered prevailing practices, which are predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

The "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003”, includes a uniform set of basic recommendations for caregivers in long term care facilities to use when assessing their residents’ need for and possible use of bed rails. Recommendations include but are not limited to the involvement of an interdisciplinary team in the assessment and approval of an individualized care plan for the resident; a risk-benefit assessment that identifies why other care interventions (alternatives to bed rail use) were not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; inspecting, evaluating, maintaining, and upgrading equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and appropriately match the equipment to patient needs, considering all relevant risk factor. In developing “the assessment”, consideration to use or not use bed rails should be based on a comprehensive assessment and identification of the resident’s needs, which include comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. Therefore, observation of residents in their bed systems, with and without bed rails, over a period of time is essential in being able to answer a series of questions to determine why bed rails would be needed (either as a restraint or a device to assist with bed mobility and transfers) and if bed rails are a safe option for their use.

Bed rails are classified as medical devices by Health Canada and come with inherent risks or hazards that can be fatal to residents. Hazards include but are not limited to suspension, suffocation, entrapment, skin injuries and entanglement. As such, bed rails must be maintained in a safe condition (as per manufacturer’s directions), be tested for zones of entrapment (zones one through four which are specific areas around the bed rail and mattress) or have the entrapment zones mitigated, and the resident must be clinically assessed to determine if they are able to understand and safely use the bed rails to minimize any inherent risks to

themselves. The population at risk for entrapment are residents who are elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, and acute urinary retention that cause them to move about the bed or try to exit from the bed. The absence of timely toileting, position change, and nursing care are factors that may also contribute to the risk of entrapment. The assessment guideline offers examples of key assessment questions that guides decision-making such as risk of falling, sleep habits, communication limitations, their mobility, cognition status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns and other factors.

The assessment guideline also emphasizes the need to document clearly whether alternatives to bed rails were used (soft rails or bolsters, perimeter reminders, reaching pole) and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or their SDM (Substitute Decision Maker) and other interdisciplinary team members, would be made about the necessity and safety of bed rail use for a particular resident and the details documented on a form (electronically or on paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the SDM or resident), the size or type of rail to be applied (rotating assist rail, fixed assist rail, 1/4, 1/2 or 3/4 bed rail), when the rails are to be applied (at night only, when in bed, with staff assistance), how many bed rails (one, two), on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

During this inspection, the licensee's clinical assessments of residents using bed rails was compared to the assessment guidelines and determined to be incomplete or lacked several key components as listed below;

A. The licensee's clinical bed safety related policies titled "Bed Safety Program" (VII-E-10.18) and "Bed Rails (VII-E10.20) ", dated May 2017, did not include any references to the above noted assessment guideline, however it included basic components and processes identified in the assessment guideline.

As part of their overall process in assessing the residents, the registered staff and Physiotherapist were directed by their policy to use a form titled "Bed System Assessment" (BSA) and the procedures included the need to "complete the form

upon move-in, and if contraindications to the use of bed rails are identified and a bed rail should not be used, other mobility resources will be considered and documented in the resident's plan of care". The policies further directed the Director of Care or designate to "communicate with the SDM/resident when they disagreed with the final assessment and wished to use a bed rail that was not appropriate". The policy did not include what steps staff could take other than education and increased frequency checks to mitigate any identified safety risks to bed rail use (entrapment, suspension, injury).

No guiding information was included in either policy as to how the resident would be assessed for safety risks while in bed. The procedures did not include how long the resident would be observed while in bed (with and without bed rails), at what frequency and what specific bed safety hazards would be monitored for and subsequently documented. The "Bed Rails" policy included general tasks for the PSW such as "observe, monitor and document". According to the ADOC, PSWs were assigned to observe residents for three nights after admission, and were required to answer eight questions related to the resident's sleep patterns in their electronic database (identified as Point of Care). These questions were initiated only for those residents who had been admitted after August 2017. The questions included whether the resident had arms or legs through the rail, attempted to climb out of bed, involuntary movements while asleep, sleeping on the edge of the bed, and whether they slept soundly with or without bed rails. Other routine checks included fall from bed, in bed or awake, restless, agitated, if repositioned, if they could reach the call bell, if they were toileted, had pain etc.

According to the policy "Bed Rails", the RN was to ensure that residents were monitored upon move-in for entrapment risks and that the RN completed the BSA. According to several day shift RNs, residents were monitored by PSWs during the night shift and that new admissions were completed by the ADOC. When the RNs were asked what documentation they completed upon admission, a form titled "Tullamore – Evaluation of Side Rail Usage" was provided for review. It was fully completed for a resident that had moved in earlier that day and a decision had been made to apply two quarter length bed rails. No sleep observation data for the resident had been collected by that point. The form was very similar to the BSA form. It included questions related to the resident's history of falls from bed, mobility, cognition or confusion and history of bed entrapment. The form was not identified in any of the home's policies.

With regards to therapeutic mattresses, the "Bed Rails" policy included clear

direction that "when used, mitigating risks (options) may include but should not be limited to "the use of gap fillers to reduce the gap between the mattress and the rails or the discontinuation of bed rails and the use of a high impact mat on the floor" and that "a bed entrapment audit is required when therapeutic surfaces are used".

B) The BSA form included a large initial component for the Physiotherapist to complete, followed by a component that the registered staff were to complete. When completed, the registered staff were to use the information collected by the PSWs and Physiotherapist and make a decision about the risk over the benefits of applying one or more bed rails for any particular resident.

Some additional relevant questions were included on the BSA form related to risk factors associated with bed injury, suspension or entrapment such as level of mobility (in bed and transfers), ability to follow directions, falls history, cognition and history of restlessness. These questions did not offer a complete picture of the resident's overall risk status. No questions or information included the resident's medical diagnosis, especially if diagnosed with any brain disorders such as Lewy Body Dementia, or neurological disorders such as Parkinson's, Multiple Sclerosis, Huntington's disease and Tourette's Syndrome, all of which cause uncontrolled body movements. Missing questions included those related to sleep disorders (hallucinations or delirium, sleep walking), communication barriers, continence, behaviours, body weakness, pain, medication use and symptomatic impact, if the resident understood the purpose of the bed rail or knew how to apply it independently, if the resident knew how to use other bed related components such as a bed remote. Without knowing the answers to these questions, determining whether the resident was a high or low risk of bed related injury was incomplete.

The BSA form included questions related to what alternatives were trialled and included a number of options but did not include positioning rolls, roll guards, defined perimeter mattress covers or soft rails/bolsters (but were identified in the policies). The form included options to document outcomes and dates trialled.

C) During the tour of the home, observations were made that approximately 90 percent of resident beds had at least one rotating assist bed rail applied, either in the transfer position or in the guard position. A rotating assist rail is approximately 3-4 feet in length and rotates at one axes point. When rotated clockwise 180 degrees, it is horizontal to the floor and in the "guard" position. When left at the 90 degree angle, it is vertical to the floor and in the "transfer" or "assist" position.

When rotated counter clockwise 180 degrees, it drops below the level of the mattress (if the bed is above knee height). When a bed rail is either in the guard position or transfer position, it is considered "applied" and therefore has the potential of injuring a resident.

A random selection of residents were chosen for review, all who were observed in bed at the time of inspection. To confirm whether residents were assessed in accordance with prevailing practices, the following resident's records were reviewed;

1. Resident #028 was observed, lying on a specific mattress with two identified rails, without any accessories in place to mitigate any entrapment zones. The mattress was soft and compressible. The mattress was not measured for entrapment zones as the maintenance person stated it automatically failed zones two, three and four. As such, the various zones should have been mitigated, or the bed rails should have been rotated back to below the level of the mattress and not used unless supervised by staff. In this particular case, the documentation was poor in determining what the benefits were of applying the bed rails. According to records, the decision to apply the bed rails was left up to the POA, without a full assessment conducted by an interdisciplinary team.

The resident's most current written plan of care included that they required extensive assistance with repositioning and turning while in bed by one or two staff members. The Physiotherapist stated that the resident could not move independently in bed and could not use the bed rails. Yet, the plan of care included that the resident was to have "two identified bed rails" for comfort as per POA. The plan of care did not include how the bed rails were to be positioned (guard, transfer or reversed and when). The plan of care also included that the resident had a number of medical and physical conditions that were all high risk factors for bed related injury.

The resident's BSA form completed in September 2017, was blank and the assessment not completed to determine risks. An RN documented on a separate assessment, one used to determine if a bed rail is a personal assistance services device or a restraint, in June 2017, that the resident was impaired, failed to check off the option that the resident was on a specific mattress, or had any history of falls. The RN identified that the resident required bed rails for positioning and transfers, despite the fact that the resident could not move independently. The RN recorded that the bed was audited for entrapment in March 2016, when in fact, the

bed was not tested. The RN recorded that the alternative included "alterations to nursing care". No alternatives were included in the assessment to determine if the resident would be more safely accommodated by using soft rails or perimeter guards. The risks were not identified and mitigated if necessary to prevent possible harm to the resident.

2. Resident #149 was provided with a specific mattress with two identified rails, before spending the first night in bed. The bed system was not tested when evaluated by the ESS in March 2017, but was considered to have failed zones two, three and four (areas in and around the bed rail and the sides of the mattress). Although not documented, zone one (space between the rungs within the bed rail) passed entrapment, as it was the same bed rail as others that had been tested and documented. Zone one is tested to ensure that a person's head cannot fit between the rungs, however other body parts such as arms are still able to pass through.

The resident's written plan of care included that the resident had a number of medical and physical conditions that were all high risk factors for bed related injury. Two specified bed rails were included on the plan of care, without a specific reason provided other than the bed rails would support activities of daily living. The plan of care did not include how the bed rails were to be positioned (guard, transfer or reversed and when).

The BSA form, completed in August 2017, which was completed initially by the Physiotherapist, included that a specified mobility aid be trialled or "bed assist rail to promote self bed mobility for repositioning/off loading of weight as alternatives to bed rail". However, no outcomes or dates were included on the BSA form to determine if alternatives were actually trialled. PT assigned the rest of the assessment to an RN. A sleep observation was conducted by PSWs over a five day period in 2017, with rotating bed rails applied. No information was included that a reasonable time period was given to assess the resident without bed rails to determine characteristics of sleep and risk factors. Progress notes made by registered staff identified that the resident was restless on a specified date throughout the day. Later that day the resident was found by staff in a position, in bed, for which they required additional assistance to reposition them.

Post incident, the Physiotherapist's notes identified that, "as per admission review, the resident tended to roll to the right and that PSW staff reported the resident sleeping on the edge of the bed". Direction was given by the Physiotherapist to monitor the resident at regular intervals to reposition to the centre of bed. Further

notes made by registered staff concluded that restlessness decreased once the identified mattress was removed and replaced with a standard foam mattress.

The therapeutic mattresses available in the home were determined to be designed with a very soft perimeter, without a reinforced edge. They are not intended to be used with residents who are restless or mobile in bed. Residents who move around too much while on these types of mattresses should be considered for alternative types of mattresses. Weight shifting causes unintended movement for the resident and any excessive movement by a resident, especially towards the edge can cause the resident to be propelled towards the edge and off the bed or towards the bed rail. In this case, the resident was not adequately assessed for the type of mattress, whether bed rails should have been applied, the type of bed rails used and their various factors upon admission.

3. Resident #090 was provided with a specific mattress. The resident was observed in bed with two identified rails. No accessories were noted to be in place in and around the bed rails to mitigate zones two, three or four.

The resident's written plan of care included the requirement to apply two identified bed rails for "bed mobility". Yet, under a different section of their plan, the resident was identified as not being able to re-position self and required total assistance from one to two staff to turn and reposition in bed. The plan of care identified the resident had a number of medical and physical conditions that were all high risk factors for bed related injury.

The resident's BSA form, as completed by the Physiotherapist in September 2017, identified that the resident required total assistance for transfers and bed mobility and that the resident was not able to follow direction and therefore bed rails were not indicated. The nursing component was not completed.

A thorough risk over benefit assessment was not completed. The decision to apply the bed rails was not based on all of the risk factors and the registered staff did not take into consideration the risks associated with the mattress.

4. Resident #101 was provided a specific mattress. The resident was observed in bed with identified rails. No accessories were noted to be in place in and around the bed rails to mitigate zones two, three or four.

The resident's written plan of care included the requirement to apply two identified

bed rails for "maintaining comfort". No further explanation was given. For bed mobility, they required "total assistance by one to two staff for turning and re-positioning", therefore the resident could not use them independently. The plan of care indicated the resident had a number of medical and physical conditions that were all high risk factors for bed related injury.

The resident's BSA form, completed in Septemeber 2017, was incomplete, or blank.

The resident's "Restraint/PASD Assessment" form identified that the resident had a number of medical and physical conditions that were risk factors for bed injury, did not identify what alternatives to bed rails were trialled and indicated that two bed rails were required for bed mobility and positioning.

A thorough risk over benefit assessment was not completed. The decision to apply the bed rails was not based on all of the risk factors and the registered staff did not take into consideration the risks associated with a the mattress.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 :

(A1)
1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.
The home's policy to promote zero tolerance of abuse and neglect of residents, titled "Prevention of Abuse and Neglect of a Resident, policy number VII-G-10.00", which included attachments (a) definitions of abuse (b) nursing checklist for investigating alleged abuse and (c) investigation template, revised 2015, outlined the following requirements that the licensee was to comply with:

i) All employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC and the Executive Director/Administrator or designate in charge of the home. Abuse for this reporting is defined as:
b) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

ii) The Investigation: 5) The ED/Administrator or designate interviews the resident, other residents, or persons who may have any knowledge of the situation. If possible, include a management witness during interviews with all residents. The witness takes detailed notes of the conversation. The nursing checklist directed staff to document subjective comments of resident.

A) During stage one resident quality inspection (RQI), an interview was conducted with resident #104.

A critical incident system (CIS) intake completed concurrently with the RQI was reviewed and it was identified the home submitted a CIS and completed an

investigation, specific to this resident alleging physical abuse, during care provided by staff #219. The home completed an investigation related allegations of rough care by staff #219 in 2017.

The home completed an interview with resident #104, on the same day they became aware of the incident. During the interview the resident shared their details related to rough care but also shared concerns related to possible abuse in relation to staff #219. In an interview with ADOC #001 in October 2017, it was confirmed that they did not ask any further questions or clarify what the resident meant in relations to these two comments and they did not obtain the detail they required.

In an interview with ADOC #001 it was confirmed that they did not investigate the incident as per the home abuse policy, as detailed notes were not taken related to the resident's concerns. They confirmed they need to obtain more detailed information. It was confirmed that the resident allegation of potential neglect and verbal/emotional abuse were not investigated.

B) On an identified date in 2017, staff observed resident #088 physically respond to resident #017. Resident #017 was observed to be injured demonstrating pain and was assessed to have an alteration in their skin integrity.

In an interview with the DOC in October 2017, it was confirmed the incident of resident to resident abuse that resulted in injury was not reported to the Director and a CIS was not submitted. It was confirmed that the homes policy to promote zero tolerance of abuse and neglect of residents was not complied with. [s. 20. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 004

WN #5: 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 :

(A1)
1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) In accordance with Ontario Regulation 79/10, s.48, required the licensee to ensure that the interdisciplinary programs including the skin and wound program, were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

The home's policy called "Skin & Wound Care Management Protocol", policy number VII-G-10.80, revised April 2016, stated that a Skin Care Coordinator will conduct weekly wound and skin care rounds with RN/RPN in resident home area, assessing pressure wounds Stage 2 or greater and wounds with other etiologies.

The Skin Care Coordinator was interviewed about the process in the home for wound care management and stated that they did not have a designated day to do wound care rounds. They usually assessed residents on Mondays; however, this was not always the case because they work as a RN on the unit regularly in addition to the duties they had as being skin care coordinator. They only assess residents that are referred to them and did not always have time to assess all residents with wounds. The rounds were not always being completed with the RN/RPN in the home area.

The DOC confirmed that the Skin Care Coordinator did not have a designated day for only wound care rounds.

The home failed to ensure that the Skin & Wound Care Management Protocol policy was complied with. (561)

B) In accordance with Ontario Regulation 79/10, s.48, required the licensee to ensure that the interdisciplinary programs including a continence care and bowel management, programs were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

The home's policy called "Continence Program-Guidelines for Care", policy number VII-D-10.00, revised January 2015, directed registered staff to assess residents upon admission, annually and when there was a significant change in condition that impacted bladder and bowel functioning. The policy referenced the bladder and bowel assessment. Furthermore, the policy indicated that staff would complete all documentation regarding resident's level of bladder/bowel continence and planned interventions in the appropriate areas of the resident's record including the care plan.

Resident #055 was coded in the MDS quarterly assessment in June 2017 to be frequently incontinent of bowel and bladder, which showed deterioration from the previous MDS dated were resident was coded to be continent of bladder and bowel. RN #302 confirmed that resident had a significant change in condition that affected their continence. The health care records were reviewed and the Bladder and Bowel Assessment could not be found in resident's record when there was a change. RN #302 confirmed that it was an expectation of the home that staff complete the Bladder and Bowel Assessment when there was a deterioration in continence and confirmed that the staff did not follow the home's policy. The written plan of care was reviewed and the level of continence and planned interventions at the time of change were not documented in the written plan of care. RN #302 confirmed that the policy was not complied with.

C) In accordance with Ontario Regulation 79/10, s.48, required the licensee to ensure that the interdisciplinary programs including a continence care and bowel management, programs were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30,

provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

The home's policy called "Continence Program-Guidelines for Care", policy number VII-D-10.00, revised January 2015, directed registered staff to assess residents upon admission, annually and when there was a significant change in condition that impacted bladder and bowel functioning. The policy referenced the bladder and bowel assessment.

Resident #077 had a significant change in continence when they returned from the hospital in 2017 with a medical intervention. The MDS assessment completed prior to admission to hospital, indicated that resident was incontinent of bowel and bladder. The MDS assessment upon return with a significant change coded in MDS, indicated resident was incontinent of bowel and coded as continent under bladder due to a medical intervention. The health care records were reviewed and the bladder and bowel assessment could not be found. RN #302 was interviewed and confirmed that it was an expectation that that assessment was completed when there was a change in continence. RN confirmed that the policy was not followed.

The licensee failed to ensure that the policy related to continence care was complied with. (561)

D) The Long Term Care Homes Act, 2007, Ontario Regulation 79/10, section 114(2), requires the licensee to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's policy called "Shift Change Monitored Drug Count", policy number 6-6, dated February 2017, stated that two staff together were to count the quantity of medications remaining and together record the date, time, quantity of medications and sign in the appropriate spaces on the form.

On an identified date, LTCH Inspector reviewed the medication carts and the process for drug destruction with the DOC and the Shift Change Monitored Medication Count was reviewed as well. The medication count showed that the registered staff dated and signed the sheet with the narcotics counted and the time showed that it was signed at 1430 hours. RPN #319 was interviewed and indicated

that this was the process and has always done that, at end of shift the narcotics were being counted together with another registered staff again.

The audit completed by a CQI Associate from the Medical Pharmacies on July 12, 2017 and indicated that the narcotic/controlled shift count sheet had not been completed by two registered staff on July 7, 2017 at 2230 hours and the home did not meet the legal and facility standards in this area.

The licensee failed to ensure that the home's policy was complied with. (561) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

(A1)
1. The licensee did not ensure that the home was kept in a safe condition and in a good state of repair.

On October 11, 2017, the flooring material in the three identified tub rooms, which was highly used by staff and residents, was observed to be in poor condition. The flooring material was known as "Terrazzo" flooring and was comprised of stones in a cement-like filler and was missing a smooth polished surface. The flooring was eroded and the stones were exposed, creating a rough and uneven surface that allowed water to sit in the pockets between the stones. The flooring material was therefore not in a state that could be easily cleaned and disinfected. The ESS did not have any plans to address the concern until it was raised during the inspection. [s. 15. (2) (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 to ensure the home is kept in a safe condition and good state of repair, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that the homes dining service; provided residents with eating aids and the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible and failed to ensure staff used proper techniques to assist residents with eating, including safe

positioning of resident who required assistance.

A) During a dining observation completed in October 2017, resident #007 was observed leaning to the side of their chair with their buttock slid out from the back of their chair causing them to lean back. The resident received total feeding assistance by staff PSW #201.

The PT care plan identified staff were to ensure resident #007 was in proper alignment when in their chair and provided specific instructions for positioning. The nutrition care plan identified the resident was at high nutrition risk, required a mechanically altered diet and required total feeding assistance from staff.

In an interview with RPN #316 it was confirmed that resident #007 was not safely positioned and required repositioning by two. The resident was repositioned by PSW #201 and RPN #316 and they were able to achieve proper upright positioning.

B) During a dining observation completed in October 2017, resident #141 notified LTCH Inspector #583 that they spilt their beverage. The resident's beverage was observed to be on the floor below their table. The resident was observed in a chair that appeared to be small for their size leaning and their buttocks was not positioned to the back of the chair.

LTCH Inspector #583 notified the staff that the resident had spilt their drink. Staff replaced the beverage sitting it on the table. The resident dropped the beverage on the floor again.

LTCH Inspector #583, again notified the staff that the resident had split their drink. LTCH Inspector #583 then observed resident #141 when staff replaced the beverage. Staff set the beverage on the table and left. The resident was not positioned close to the table, brakes were not applied to their wheelchair and items on the table were not easily within reach causing the resident to have further spills.

Inspector #583 then got RPN #316, and it was confirmed that the resident did not get the personal assistance required to eat and drink as comfortably and independently as possible. It was also confirmed that resident #141 was not positioned in an upright position and that they could not reposition themselves.

A review of resident #141's nutrition care plan identified they were at high nutrition

risk, had swallowing issues and required set up at meal time with items placed in front of them due to a medical condition.

C) During a dining observation completed in October 2017, resident #113 was observed sitting at the table in their chair and the table height was not at an appropriate level. The resident was able to eat independently with cuing and some assistance but was having difficulty feeding themselves. They were observed dropping food off their plate when trying to scoop it up multiple times.

In an interview with PSW staff #206 it was confirmed resident #113 was not provided with any eating aids or positioned at a table height to eat as independently and comfortably as possible. [s. 73. (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 home's dining service provides residents with eating aids and the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible and to ensure proper techniques are used to assist residents with eating, including the safe positioning of residents who require assistance, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

(A1)
1. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were developed and implemented for cleaning of resident care equipment and staff equipment.

1. On October 6 and 11, 2017, care carts located in various locations, either in corridors or resident bathing rooms, were observed by inspectors #561 and #120 to be stained and dirty in appearance. According to the licensee's various policies, procedures and schedules related to equipment cleaning (Equipment Cleaning - Resident Care and Medical Equipment VII-H-10.50, Nursing and Resident Care Equipment Cleaning Frequency VII-H-10.30(a) and Shower and Tub Rooms XII-E-10.90), the cleaning requirements for care carts used by personal support workers (PSW) for linens and hygiene supplies, was not included. The ESS was informed on October 11, 2017, and by October 16, 2017, all of the care carts were cleaned. The requirement to clean the care carts on a daily basis was added to the PSW and housekeeper routines.

2. On October 6 and 11, 2017, shower chairs located in the tub/shower rooms on three identified home areas were observed with a mesh back rest that were discoloured (pink) and had water scale build up on them. According to the licensee's various policies, procedures and schedules related to equipment cleaning (Equipment Cleaning - Resident Care and Medical Equipment VII-H-10.50, Nursing and Resident Care Equipment Cleaning Frequency VII-H-10.30(a)), the cleaning of shower chairs were the responsibility of both the housekeepers and the PSWs. However, the procedures did not include how to clean components of the chair that could not be wiped or could be scrubbed with a brush. The ESS was informed on October 11, 2017, and by October 16, 2017, all of the mesh back rests were removed and had been laundered. The requirement to launder the mesh back rests were added to the PSW and housekeeper routines.

The licensee therefore did not ensure that procedures were developed to include the cleaning of resident care equipment and staff equipment and that the procedures were implemented. [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for the cleaning of resident care equipment and staff equipment, to be implemented voluntarily.

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 :

(A1)
1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #090 developed two areas of altered skin integrity.

Resident #090 was identified to have an area of altered skin integrity in September 2017. The POC documentation completed the next day, showed that PSW staff had documented that no skin issues were observed.

The weekly skin assessment completed on an identified date in October 2017, indicated that resident #090 had two areas of altered skin integrity. The POC documentation completed on the same date showed that PSW staff documented that no skin issues were observed on all shifts. Over the next several days, PSW staff documented that no skin issues were observed on evening shifts and night shifts; only on day shifts PSWs documented that resident had altered skin integrity.

The interview with PSW staff #203 indicated that staff were to document any issues they observed on daily basis on every shift, and only when the area was cleared of issues they would document 'none was observed'. The DOC was interviewed and indicated that PSWs were expected to document their assessments on every shift and stated that perhaps they were not clear on proper documentation. It was confirmed that the licensee failed to ensure that skin assessments completed by PSW staff were documented. [s. 30. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that an individualized menu was developed for each resident whose needs could not be met through the home's menu cycle.

During an interview with resident #104 they shared they had a lack of choice at meal time as they followed a specific diet and there weren't choices available in the home. The written goal documented in the nutrition care plan was that the home would "provide appropriate diet according to preferences". The diet order specified the residents diet preferences.

In an interview with the Director of Dietary Services and the Food Services Supervisor on October 10, 2017, it was confirmed that an identified number of resident's in the home followed a specific diet. They shared the home was not purchasing and did not have any of the food items available to meet the residents specified needs at the time of the inspection. It was confirmed that the home did not develop an individualized menu for resident #104 whose needs could not be met through the home's menu cycle. [s. 71. (5)]

(A1)
The following Non-Compliance has been Revoked: WN #11

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Issued on this 2 day of February 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : KELLY HAYES (583) - (A1)

Inspection No. / No de l'inspection : 2017_561583_0018 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 023282-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 02, 2018;(A1)

Licensee / Titulaire de permis :

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8

LTC Home / Foyer de SLD :

Tullamore Care Community
133 KENNEDY ROAD SOUTH, BRAMPTON, ON, L6W-3G3

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

Ministère 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 Administrator / Nom de l'administratrice ou de l'administrateur : Astrida Kalnins

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To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee will do the following:

1. Ensure resident #043 is reassessed and their nutrition plan of care is reviewed and revised to reflect the residents required diet texture.
2. Ensure resident #007 is reassessed and their falls plan of care is reviewed and revised to include PT's recommendations and strategies for fall monitoring.
3. Ensure resident #055 is reassessed and their continence plan of care is reviewed and revised to reflect the required continence products.
4. Ensure resident #077 is reassessed and their continence and toileting plan of care is reviewed and revised to include clear direction for catheter use.
5. Ensure resident #013 is reassessed and their care plan related to infections are removed when resolved.
6. Ensure resident #071 is reassessed and their falls care plan is reviewed and revised.
7. Ensure resident #028 is reassessed and their nurtition care plan is reviewed and revised related to added protein content.

Grounds / Motifs :

(A1)
1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Homes Act, Regulation 79/10. In respect to severity, there is a potential for actual harm (2), for scope, the number of residents who have not been adequately assessed is a pattern (2) and previous non-compliance related to the plan of care was issued under the same section (4) on April 21, 2017, February 22, 2017, September 26, 2016, July 14, 2015, as a (VPC).

The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any time when the goal is met, the care set needs changed or the care set out in the plan was no longer necessary or when the care set out in the plan was not effective.

A) A review of resident #043's interdisciplinary care conference notes, identified they were at high nutrition risk, and required nutrition interventions due to their medical conditions.

During a lunch observation in October 2017, resident #043 was on a regular texture diet and was served their meal but their nutrition intervention was not provided. An interview was completed with the two cooks working in the kitchen and they shared they did not provide the resident the intervention as the resident usually didn't take it. They shared the resident was having difficulty with their diet texture. During the lunch service observation resident #043 did not eat well and in an interview with the resident they identified they were having difficulty with their diet texture.

In an interview with the DOC and ADOC on October 18, 2017, it was confirmed that resident #043 was not reassessed and the nutrition plan of care was not updated when it was identified the residents diet texture care needs changed and when it was identified the intervention had not been effective. (583)

B) Resident #007 who was assessed to be high risk for falls was observed by staff to have a fall on an identified date in 2017.

A falls incident-post fall huddle was completed, which included immediate action taken but did not identify any changes required to the plan of care. The Physiotherapist (PT) assessment documented at the same time as the post fall huddle, provided fall risk reduction recommendations with specific interventions for the resident.

A review of the falls care plan showed no revisions were made after the fall nor had any been made over a one year period. The plan of care was not revised to include the PT's recommendations and did not identify strategies for fall monitoring. In an interview with ADOC #001 it was confirmed that resident #007's falls plan of care was not revised when the resident's needs changed. (583)

C) Resident #055 had a plan of care indicating that they were frequently incontinent of bladder and bowel. Health care records were reviewed and indicated that the resident had a significant change of health condition and their continence had deteriorated. Resident was not reassessed and the plan of care was not revised at that time.

RN #302 confirmed that resident had a change in continence and was now frequently incontinent of bladder and bowel and required to wear incontinent product. The current written plan of care was reviewed and indicated that resident was not wearing

any incontinent products and the change of continence was not documented in the written plan of care.

In an interview with the RN #302 indicated that the expectation of staff was to reassess the resident when they had a deterioration in continence and the plan of care should have been revised to reflect the change.

The licensee failed to ensure that resident was reassessed the plan of care reviewed and revised when the resident's needs changed. (561)

D) Resident #077 had a significant change in health condition which required an intervention while in the hospital in 2017. Prior to hospitalization resident was incontinent of bowel and bladder according to the Minimum Data SET (MDS) quarterly assessment. The MDS significant change in condition assessment indicated resident was incontinent of bowel and coded as continent of bladder.

The health care records revealed that resident was not reassessed when they had the change in continence. RN #302 confirmed that the resident was not reassessed using the bladder and bowel assessment tool in Point Click Care (PCC) when they had a change in continence.

Furthermore, when resident returned from the hospital with a medial intervention related to continence care staff did not obtain an order for the intervention from the physician. A note was added to the doctor book; however, the order was never obtained. The Treatment Administration Record (TAR) and Medication Administration Record (MAR) were reviewed and the order for the intervention could not be found. RN #302 was interviewed and indicated that an order for the intervention should have been obtained when resident returned from the hospital.

The licensee failed to ensure that resident was reassessed when they had a significant change in condition which required a medical intervention. (561)

E) Resident #013's health care record was reviewed and the written plan of care identified the resident to be on specified precautions related to their medical condition. Resident 013's room was observed and the precautions signage was present on the door. The Infection Control Surveillance Record for October was reviewed and the resident was not added to the surveillance. Further review of health care record revealed that resident was on precautions on an identified date in

2017 and had treatment for a medical condition and it was now completed. Resident was currently free from infections. The DOC indicated that resident was no longer symptomatic and was not on precautions. The DOC confirmed that the written plan of care was not revised when the resident completed their treatment and no longer required precautions.

The licensee failed to ensure that resident's written plan of care was revised when the care needs changed. (561)

F) Resident #071 had a plan of care indicating that they were at high risk for falls and was a frequent faller. The health care records were reviewed and revealed that resident sustained 10 falls over a three month period in 2017. All these falls resulted from resident attempting to self transfer from various locations. Most falls also occurred during identified times. The progress notes were reviewed and the Physiotherapist completed assessments of the resident post fall and recommended a number of interventions.

The Physiotherapist was interviewed in October 2017 and confirmed that they had recommended these interventions; however it was the nursing department expectation to review the recommendations and decide whether they would be appropriate for the resident and the registered staff would then revise the care plans to reflect current needs of the resident. PSW #203 who provided direct care to the resident indicated that resident was at high risk for falls and shared what falls prevention interventions were being provided; however, PSW #203 indicated a number of the interventions were no longer effective that were in the falls care plan. The staff shared new interventions that they were providing. The written plan of care was not revised when these interventions changed.

The RN #300 was interviewed and confirmed that the written plan of care was not revised with the recommendation made by the Physiotherapist. The ED was interviewed and confirmed that there was a gap between the recommendations made by the physiotherapist and the nursing department and the plan of care was not revised with the falls interventions.

The licensee failed to ensure that the plan of care was revised when the care needs changed for this resident in relation to falls. (561)

G) The Registered Dietitian (RD) was sent three referrals for resident #028 for

altered skin integrity on identified dates in 2017 over a two month period.

The resident was assessed as having an area of altered skin integrity that showed no signs of improvement over a three month period in 2017, since the area was initially identified.

During the first assessment completed when the altered skin integrity was identified, the RD added a dietary intervention at breakfast to increase the protein content of resident #028's diet.

During the second and third assessment, completed by the RD no changes were made to resident #028's nutrition interventions or plan of care.

In an interview with the RD in October 2017, it was confirmed that resident #028, would need to eat 100% of their meals and special intervention daily to meet their protein requirements and that the resident's intake was often less consuming anywhere from 50 to 100 %. It was confirmed resident #028, still had altered skin integrity with no improvement. It was confirmed that the resident's current diet may not also meet the residents protein requirements and that no new interventions to increase the protein content of the diet were added when the resident's skin integrity had not improved. (583) (583)

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

Mar 05, 2018

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. Duty to protect

Order / Ordre :

The licensee will do the following:

1. Ensure the home's policy VIII-D-10.30(a)(b)(c), revised, January 2015, is followed for resident #043 and all residents requiring specified treatment.

2. Develop a monitoring process to ensure the safety of resident #043 following the specified treatment.

3. Ensure all resident are protected from abuse by resident #088.
4. Develop specific interventions on how staff are to monitor resident #088.
5. Develop specific interventions of how staff are are to assist resident #088 at times when the resident is exhibiting responsive behaviours due to their known triggers.
6. Include these detailed inventions in resident #088's responsive behaviour care plan.

Grounds / Motifs :

(A1)
1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long-Term Care Homes Act, Regulation 79/10. In respect to severity, there is actual harm and risk (3), for scope, the number of residents who have not been adequately assessed is isolated (1) and previous non-compliance related to duty to protect was issued under the same section (4) on July 7, 2017 (CO).

The licensee failed to ensure that a resident was not neglected by the licensee or staff.

A) For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On an identified date in 2017, resident #043 had a fall. The post fall huddles assessment identified the resident's had a medical incident related to a known medical condition that contributed to the fall. The resident was monitored and treated but the condition was not treated according to the homes policies. A note was left in the doctor's book for the physician to reassess the resident's condition on their next scheduled visit. The physician was notified at the time of the incident.

At the time of the fall the resident's medical condition was being monitored twice a week.

The next day when the resident was being monitored the resident had another incident related to their medical condition. There was no documentation of what action was taken and the physician was not notified. In an interview with the RD in October 2017, it was confirmed they did not receive a referral for resident #043's two incidents related to their medical condition.

In an interview with ADOC #001 and the DOC on October 18, 2017, it was confirmed that there was a pattern of inaction by the home of the management of resident #043's two medical events and that the pattern of inaction put the resident at further risk of having another event. It was confirmed that the definition of "neglect" meaning the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health, safety or well-being was identified.

B) The licensee failed to ensure that residents were protected from abuse by anyone.

For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

A review of resident #088 care plan identified they had known verbal and physical responsive behaviours towards other residents, related to environmental triggers. Resident #088 was independent with mobility with the used a mobility aid. They were observed throughout the inspection in areas where known environmental triggers were present.

In an interview with the DOC, ADOC #001 and BSO Champion it was shared in the homes environment that resident #088's triggers for responsive behaviours were difficult to avoid and the resident could not always be monitored. Three incidents occurred in 2017, when effective interventions were not provided for resident #088's responsive behaviours.

On an identified date in 2017, staff where notified by resident #132 that resident #088 demonstrate a responsive behaviour towards them causing injury.

On a second identified date in 2017, staff observed resident #088 demonstrate responsive behaviours towards resident #017 causing an injury.

On a third identified date in 2017, staff observed resident #088 demonstrate responsive behaviours towards resident #131 causing an injury.

In addition to the physical responsive behaviours which caused injury there were a number of additional incidents where resident #088 demonstrated responsive behaviours that had potential to harm other residents.

In an interview with the DOC and ADOC in October 2017, it was confirmed that resident #132, #017 and #131 were not protected from abuse by resident #088 who had known physical responsive behaviours with previously identified triggers. (583)

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

Jan 22, 2018

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 :

(A1)
The licensee shall complete the following:

1. Amend the home's existing "Bed System Assessment" form and process related to resident clinical assessments and the use of bed rails to include additional relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings", (U.S. F.D.A, April 2003) which is recommended as the prevailing practice for individualized resident assessment of bed rails. The amended form and or process shall, at a minimum, include the following:

a. the observation of the resident while sleeping for a specified period of time, to establish their bed mobility habits, patterns of sleep, transfer abilities, behaviours and other relevant risk factors prior to the application of any bed rail(s) or bed system accessory (bed remote control) or alternative to bed rails (bolster, positioning rolls, roll guards); and
b. the observation of the resident while sleeping for a specific period of time, to establish safety risks to the resident after a bed rail, accessory or alternative has been applied and deemed necessary; and
c. the alternative or alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during a specified observation period.

2. All registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply the expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006", and the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings", U.S. F.D.A, April 2003) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. The written plan of care shall include at a minimum information about the resident's ability to independently use the bed rail(s) or whether staff supervision is required, why bed rails are being used or applied, how many, on what side of the bed, bed rail type or size and when they are to be applied (when in bed, at all times, when care provided etc).

4. Develop or acquire information fact sheets or pamphlets identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks/hazards of bed rail use, available alternatives to bed rails, how residents are assessed upon admission, how bed systems are evaluated for entrapment zones, the role of both the SDM and licensee with respect to resident assessments and any other relevant information regarding bed safety. The information shall be disseminated to relevant staff, families and residents and/or SDM.

5. Amend the policies titled "Bed Safety Program" (VII-E-10.18) and "Bed Rails (VII-E10.20)", to include additional and relevant information noted in the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings (U.S. F.D.A, April 2003)" and "A Guide for Modifying Bed Systems and Using Accessories to Reduce Entrapment, (U.S. F.D.A, June 2006)". At a minimum the policy shall include links to the above noted guidelines and;

a) additional details of the process of assessing residents upon admission, after admission and when a change in the resident's condition has been identified and when a change to the bed system has been made to monitor

residents for risks associated with bed rail use and the use of any bed related attachments/accessories on an on-going basis; and
b) guidance for the assessors in being able to make clear decisions based on the data acquired by the interdisciplinary team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
c) what specific options are available to mitigate any identified bed safety related hazards such as entrapment, suspension or injury risks; and
d) the role of the SDM and/or resident in selecting the appropriate device for the resident's unique identified care needs; and
e) specific responsibilities of personal support workers with respect to observing residents in bed related to their bed systems (which includes bed rails, bed frames, accessories, mattresses, bed remote controls) and associated safety hazards.

6. Provide face to face training to all relevant staff (PSWs, registered staff, OT/PT) who are affiliated with residents and/or their bed systems with respect to the home's amended bed safety assessment policies and procedures, resident clinical assessments, specific staff roles and responsibilities, how to determine if a resident is at risk of entrapment, strangulation, injury or entanglement while in their bed system and the applicable course of action to be taken when safety risks are identified.

Grounds / Motifs :

(A1)
1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long-Term Care Homes Act, Regulation 79/10. In respect to severity, there is potential for actual harm (2), for scope, the number of residents who have not been adequately assessed is widespread (3) and previous non-compliance related to bed rail use was issued under the same section (4) on July 7, 2014 (CO), July 14, 2015 (VPC) and February 22, 2017 (VPC).

The licensee did not ensure that, where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the residents.

On August 21, 2012, a notice was issued to the Long-Term Care Home Administrators from the Ministry of Health and Long-Term Care, Performance

Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". These are the “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" and “A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006”, and are considered prevailing practices, which are predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

The "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003”, includes a uniform set of basic recommendations for caregivers in long term care facilities to use when assessing their residents’ need for and possible use of bed rails. Recommendations include but are not limited to the involvement of an interdisciplinary team in the assessment and approval of an individualized care plan for the resident; a risk-benefit assessment that identifies why other care interventions (alternatives to bed rail use) were not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; inspecting, evaluating, maintaining, and upgrading equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and appropriately match the equipment to patient needs, considering all relevant risk factor. In developing “the assessment”, consideration to use or not use bed rails should be based on a comprehensive assessment and identification of the resident’s needs, which include comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. Therefore, observation of residents in their bed systems, with and without bed rails, over a period of time is essential in being able to answer a series of questions to determine why bed rails would be needed (either as a restraint or a device to assist with bed mobility and transfers) and if bed rails are a safe option for their use.

Bed rails are classified as medical devices by Health Canada and come with inherent risks or hazards that can be fatal to residents. Hazards include but are not limited to suspension, suffocation, entrapment, skin injuries and entanglement. As such, bed rails must be maintained in a safe condition (as per manufacturer’s directions), be

tested for zones of entrapment (zones one through four which are specific areas around the bed rail and mattress) or have the entrapment zones mitigated, and the resident must be clinically assessed to determine if they are able to understand and safely use the bed rails to minimize any inherent risks to themselves. The population at risk for entrapment are residents who are elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, and acute urinary retention that cause them to move about the bed or try to exit from the bed. The absence of timely toileting, position change, and nursing care are factors that may also contribute to the risk of entrapment. The assessment guideline offers examples of key assessment questions that guides decision-making such as risk of falling, sleep habits, communication limitations, their mobility, cognition status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns and other factors.

The assessment guideline also emphasizes the need to document clearly whether alternatives to bed rails were used (soft rails or bolsters, perimeter reminders, reaching pole) and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or their SDM (Substitute Decision Maker) and other interdisciplinary team members, would be made about the necessity and safety of bed rail use for a particular resident and the details documented on a form (electronically or on paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the SDM or resident), the size or type of rail to be applied (rotating assist rail, fixed assist rail, 1/4, 1/2 or 3/4 bed rail), when the rails are to be applied (at night only, when in bed, with staff assistance), how many bed rails (one, two), on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

During this inspection, the licensee's clinical assessments of residents using bed rails was compared to the assessment guidelines and determined to be incomplete or lacked several key components as listed below;

A. The licensee's clinical bed safety related policies titled "Bed Safety Program" (VII-E-10.18) and "Bed Rails (VII-E10.20) ", dated May 2017, did not include any references to the above noted assessment guideline, however it included basic

components and processes identified in the assessment guideline.

As part of their overall process in assessing the residents, the registered staff and Physiotherapist were directed by their policy to use a form titled "Bed System Assessment" (BSA) and the procedures included the need to "complete the form upon move-in, and if contraindications to the use of bed rails are identified and a bed rail should not be used, other mobility resources will be considered and documented in the resident's plan of care". The policies further directed the Director of Care or designate to "communicate with the SDM/resident when they disagreed with the final assessment and wished to use a bed rail that was not appropriate". The policy did not include what steps staff could take other than education and increased frequency checks to mitigate any identified safety risks to bed rail use (entrapment, suspension, injury).

No guiding information was included in either policy as to how the resident would be assessed for safety risks while in bed. The procedures did not include how long the resident would be observed while in bed (with and without bed rails), at what frequency and what specific bed safety hazards would be monitored for and subsequently documented. The "Bed Rails" policy included general tasks for the PSW such as "observe, monitor and document". According to the ADOC, PSWs were assigned to observe residents for three nights after admission, and were required to answer eight questions related to the resident's sleep patterns in their electronic database (identified as Point of Care). These questions were initiated only for those residents who had been admitted after August 2017. The questions included whether the resident had arms or legs through the rail, attempted to climb out of bed, involuntary movements while asleep, sleeping on the edge of the bed, and whether they slept soundly with or without bed rails. Other routine checks included fall from bed, in bed or awake, restless, agitated, if repositioned, if they could reach the call bell, if they were toileted, had pain etc.

According to the policy "Bed Rails", the RN was to ensure that residents were monitored upon move-in for entrapment risks and that the RN completed the BSA. According to several day shift RNs, residents were monitored by PSWs during the night shift and that new admissions were completed by the ADOC. When the RNs were asked what documentation they completed upon admission, a form titled "Tullamore – Evaluation of Side Rail Usage" was provided for review. It was fully completed for a resident that had moved in earlier that day and a decision had been made to apply two quarter length bed rails. No sleep observation data for the

resident had been collected by that point. The form was very similar to the BSA form. It included questions related to the resident's history of falls from bed, mobility, cognition or confusion and history of bed entrapment. The form was not identified in any of the home's policies.

With regards to therapeutic mattresses, the "Bed Rails" policy included clear direction that "when used, mitigating risks (options) may include but should not be limited to "the use of gap fillers to reduce the gap between the mattress and the rails or the discontinuation of bed rails and the use of a high impact mat on the floor" and that "a bed entrapment audit is required when therapeutic surfaces are used".

B) The BSA form included a large initial component for the Physiotherapist to complete, followed by a component that the registered staff were to complete. When completed, the registered staff were to use the information collected by the PSWs and Physiotherapist and make a decision about the risk over the benefits of applying one or more bed rails for any particular resident.

Some additional relevant questions were included on the BSA form related to risk factors associated with bed injury, suspension or entrapment such as level of mobility (in bed and transfers), ability to follow directions, falls history, cognition and history of restlessness. These questions did not offer a complete picture of the resident's overall risk status. No questions or information included the resident's medical diagnosis, especially if diagnosed with any brain disorders such as Lewy Body Dementia, or neurological disorders such as Parkinson's, Multiple Sclerosis, Huntington's disease and Tourette's Syndrome, all of which cause uncontrolled body movements. Missing questions included those related to sleep disorders (hallucinations or delirium, sleep walking), communication barriers, continence, behaviours, body weakness, pain, medication use and symptomatic impact, if the resident understood the purpose of the bed rail or knew how to apply it independently, if the resident knew how to use other bed related components such as a bed remote. Without knowing the answers to these questions, determining whether the resident was a high or low risk of bed related injury was incomplete.

The BSA form included questions related to what alternatives were trialled and included a number of options but did not include positioning rolls, roll guards, defined perimeter mattress covers or soft rails/bolsters (but were identified in the policies). The form included options to document outcomes and dates trialled.

C) During the tour of the home, observations were made that approximately 90 percent of resident beds had at least one rotating assist bed rail applied, either in the transfer position or in the guard position. A rotating assist rail is approximately 3-4 feet in length and rotates at one axes point. When rotated clockwise 180 degrees, it is horizontal to the floor and in the "guard" position. When left at the 90 degree angle, it is vertical to the floor and in the "transfer" or "assist" position. When rotated counter clockwise 180 degrees, it drops below the level of the mattress (if the bed is above knee height). When a bed rail is either in the guard position or transfer position, it is considered "applied" and therefore has the potential of injuring a resident.

A random selection of residents were chosen for review, all who were observed in bed at the time of inspection. To confirm whether residents were assessed in accordance with prevailing practices, the following resident's records were reviewed;

1. Resident #028 was observed, lying on a specific mattress with two identified rails, without any accessories in place to mitigate any entrapment zones. The mattress was soft and compressible. The mattress was not measured for entrapment zones as the maintenance person stated it automatically failed zones two, three and four. As such, the various zones should have been mitigated, or the bed rails should have been rotated back to below the level of the mattress and not used unless supervised by staff. In this particular case, the documentation was poor in determining what the benefits were of applying the bed rails. According to records, the decision to apply the bed rails was left up to the POA, without a full assessment conducted by an interdisciplinary team.

The resident's most current written plan of care included that they required extensive assistance with repositioning and turning while in bed by one or two staff members. The Physiotherapist stated that the resident could not move independently in bed and could not use the bed rails. Yet, the plan of care included that the resident was to have "two identified bed rails" for comfort as per POA. The plan of care did not include how the bed rails were to be positioned (guard, transfer or reversed and when). The plan of care also included that the resident had a number of medical and physical conditions that were all high risk factors for bed related injury.

The resident's BSA form completed in September 2017, was blank and the assessment not completed to determine risks. An RN documented on a separate assessment, one used to determine if a bed rail is a personal assistance services

device or a restraint, in June 2017, that the resident was impaired, failed to check off the option that the resident was on a specific mattress, or had any history of falls. The RN identified that the resident required bed rails for positioning and transfers, despite the fact that the resident could not move independently. The RN recorded that the bed was audited for entrapment in March 2016, when in fact, the bed was not tested. The RN recorded that the alternative included "alterations to nursing care". No alternatives were included in the assessment to determine if the resident would be more safely accommodated by using soft rails or perimeter guards. The risks were not identified and mitigated if necessary to prevent possible harm to the resident.

2. Resident #149 was provided with a specific mattress with two identified rails, before spending the first night in bed. The bed system was not tested when evaluated by the ESS in March 2017, but was considered to have failed zones two, three and four (areas in and around the bed rail and the sides of the mattress). Although not documented, zone one (space between the rungs within the bed rail) passed entrapment, as it was the same bed rail as others that had been tested and documented. Zone one is tested to ensure that a person's head cannot fit between the rungs, however other body parts such as arms are still able to pass through.

The resident's written plan of care included that the resident had a number of medical and physical conditions that were all high risk factors for bed related injury. Two specified bed rails were included on the plan of care, without a specific reason provided other than the bed rails would support activities of daily living. The plan of care did not include how the bed rails were to be positioned (guard, transfer or reversed and when).

The BSA form, completed in August 2017, which was completed initially by the Physiotherapist, included that a specified mobility aid be trialled or "bed assist rail to promote self bed mobility for repositioning/off loading of weight as alternatives to bed rail". However, no outcomes or dates were included on the BSA form to determine if alternatives were actually trialled. PT assigned the rest of the assessment to an RN. A sleep observation was conducted by PSWs over a five day period in 2017, with rotating bed rails applied. No information was included that a reasonable time period was given to assess the resident without bed rails to determine characteristics of sleep and risk factors. Progress notes made by registered staff identified that the resident was restless on a specified date throughout the day. Later that day the resident was found by staff in a position, in bed, for which they required additional

assistance to reposition them.

Post incident, the Physiotherapist's notes identified that, "as per admission review, the resident tended to roll to the right and that PSW staff reported the resident sleeping on the edge of the bed". Direction was given by the Physiotherapist to monitor the resident at regular intervals to reposition to the centre of bed. Further notes made by registered staff concluded that restlessness decreased once the identified mattress was removed and replaced with a standard foam mattress.

The therapeutic mattresses available in the home were determined to be designed with a very soft perimeter, without a reinforced edge. They are not intended to be used with residents who are restless or mobile in bed. Residents who move around too much while on these types of mattresses should be considered for alternative types of mattresses. Weight shifting causes unintended movement for the resident and any excessive movement by a resident, especially towards the edge can cause the resident to be propelled towards the edge and off the bed or towards the bed rail. In this case, the resident was not adequately assessed for the type of mattress, whether bed rails should have been applied, the type of bed rails used and their various factors upon admission.

3. Resident #090 was provided with a specific mattress. The resident was observed in bed with two identified rails. No accessories were noted to be in place in and around the bed rails to mitigate zones two, three or four.

The resident's written plan of care included the requirement to apply two identified bed rails for "bed mobility". Yet, under a different section of their plan, the resident was identified as not being able to re-position self and required total assistance from one to two staff to turn and reposition in bed. The plan of care identified the resident had a number of medical and physical conditions that were all high risk factors for bed related injury.

The resident's BSA form, as completed by the Physiotherapist in September 2017, identified that the resident required total assistance for transfers and bed mobility and that the resident was not able to follow direction and therefore bed rails were not indicated. The nursing component was not completed.

A thorough risk over benefit assessment was not completed. The decision to apply the bed rails was not based on all of the risk factors and the registered staff did not

take into consideration the risks associated with the mattress.

4. Resident #101 was provided a specific mattress. The resident was observed in bed with identified rails. No accessories were noted to be in place in and around the bed rails to mitigate zones two, three or four.

The resident's written plan of care included the requirement to apply two identified bed rails for "maintaining comfort". No further explanation was given. For bed mobility, they required "total assistance by one to two staff for turning and re-positioning", therefore the resident could not use them independently. The plan of care indicated the resident had a number of medical and physical conditions that were all high risk factors for bed related injury.

The resident's BSA form, completed in Septemeber 2017, was incomplete, or blank.

The resident's "Restraint/PASD Assessment" form identified that the resident had a number of medical and physical conditions that were risk factors for bed injury, did not identify what alternatives to bed rails were trialled and indicated that two bed rails were required for bed mobility and positioning.

A thorough risk over benefit assessment was not completed. The decision to apply the bed rails was not based on all of the risk factors and the registered staff did not take into consideration the risks associated with a the mattress.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. (120)

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

Jun 01, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2017_546585_0004, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee will do the following:

1. Ensure any suspected or known incidents of alleged abuse are immediately reported to the Director of MOHLTC.
2. Ensure all incidents of alleged abuse including verbal and emotional abuse are investigated as directed in the homes policy and detailed notes of the conversation with residents are documented.

Grounds / Motifs :

(A1)
1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long-Term Care Homes Act, Regulation 79/10. In respect to severity, there is a potential for actual harm (2), for scope, the number of incidents that had not been reported or investigated is isolated (1) and previous non-compliance related to the policy to promote zero tolerance of abuse and neglect was issued under the same section (4) on April 21, 2017 (CO).
The licensee failed to ensure that the policy to promote zero tolerance of abuse and

neglect of residents was complied with.

The home's policy to promote zero tolerance of abuse and neglect of residents, titled "Prevention of Abuse and Neglect of a Resident, policy number VII-G-10.00", which included attachments (a) definitions of abuse (b) nursing checklist for investigating alleged abuse and (c) investigation template, revised 2015, outlined the following requirements that the licensee was to comply with:

i) All employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC and the Executive Director/Administrator or designate in charge of the home. Abuse for this reporting is defined as:
b) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

ii) The Investigation: 5) The ED/Administrator or designate interviews the resident, other residents, or persons who may have any knowledge of the situation. If possible, include a management witness during interviews with all residents. The witness takes detailed notes of the conversation. The nursing checklist directed staff to document subjective comments of resident.

A) During stage one resident quality inspection (RQI), an interview was conducted with resident #104.

A critical incident system (CIS) intake completed concurrently with the RQI was reviewed and it was identified the home submitted a CIS and completed an investigation, specific to this resident alleging physical abuse, during care provided by staff #219. The home completed an investigation related allegations of rough care by staff #219 in 2017.

The home completed an interview with resident #104, on the same day they became aware of the incident. During the interview the resident shared their details related to rough care but also shared concerns related to possible abuse in relation to staff #219. In an interview with ADOC #001 in October 2017, it was confirmed that they did not ask any further questions or clarify what the resident meant in relations to these two comments and they did not obtain the detail they required.

In an interview with ADOC #001 it was confirmed that they did not investigate the incident as per the home abuse policy, as detailed notes were not taken related to the resident's concerns. They confirmed they need to obtain more detailed information. It was confirmed that the resident allegation of potential neglect and verbal/emotional abuse were not investigated.

B) On an identified date in 2017, staff observed resident #088 physically respond to resident #017. Resident #017 was observed to be injured demonstrating pain and was assessed to have an alteration in their skin integrity.

In an interview with the DOC in October 2017, it was confirmed the incident of resident to resident abuse that resulted in injury was not reported to the Director and a CIS was not submitted. It was confirmed that the homes policy to promote zero tolerance of abuse and neglect of residents was not complied with. (583)

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

Jan 22, 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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 2 day of February 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KELLY HAYES - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Hamilton