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
Aug 31, 2018;	2018_723606_0014 (A1)	011627-18	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

Amended by JANET GROUX (606) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home provided evidence that there were weekly skin assessments completed and in place for resident #007's skin impairment. The reports were modified to reflect these findings were removed in the inspection report and from the grounds in the order.

Issued on this 31 day of August 2018 (A1)

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

Original report signed by the inspector.

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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): June 5, 6, 7, 8, 11, 12, 13, 15, 18, 19, 20, 21, and 22, 2018.

The following intakes were inspected concurrently with the RQI:

Log #011627-18-inspection # 2017_561583_0018 (A1)-FU #003 O.Reg 79/10, s. 15. (1) bedrails;

Log #005160-18 regarding a fracture of unknown cause.

Log #008665-18 regarding resident neglect of care.

Log #005910-18 regarding falls prevention and management, skin and wound management, and reporting and complaints; and

Log #012228-18 regarding staff to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the interim Executive Director (ED), interim Director of Care (DOC), Associate Director of Care (ADOC), interim Environmental Services Manager (ESM), Resident Relations Coordinator (RCC), Director of Dietary Services (DDS), Director of Recreation and Programs (DRP), Recreation Therapy Aides (RTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Housekeeping Aides, Laundry Aides, Dietary Aides, the President of the Residents and Family Councils, Substitute Decision Makers (SDM), and residents.

During the course of this inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, interviewed the home's Residents' and Family Council president, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

- **14 WN(s)**
- **6 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

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

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

A) The interim Environmental Services Manager (ESM) and maintenance person confirmed that an approved weighted cone and cylinder tool was used to complete their bed system evaluation for entrapment zones one through four of all resident bed systems in April 2018. All of the bed systems passed all four zones of entrapment, with the exception of eight beds with therapeutic mattresses. The residents using these beds were provided with triangular shaped foam accessories that were designed to be wedged in between the bed rail and the mattress (zone three). However, during the inspection on June 14, 2018, the accessories were found to be sitting on top of the therapeutic mattresses, next to the bed rails that were seen in either the guard position (horizontal) or the transfer position (vertical), whether residents were in bed or not. The covering on the accessory was made of cotton or polyester and when stuffed into zone three by inspector #120, the accessory slid out of position. The purpose of the accessory was to mitigate any risks associated with zone three gaps, to fill the void to prevent a limb from sliding down into that zone and getting entrapped. The accessories therefore did not serve any particular purpose and could easily fall off the bed or be removed.

B) The bed rails on the bed frames were designed to rotate into more than one position. When in the highest or vertical position (transfer or assist position) the bed rails in bed A appeared to have a larger than normal space between the bed rail and the side of the mattress. When the interim ESM was requested to measure the zone between the mattress and the bed rail while in the transfer position using the weighted tool, zone three did not pass entrapment. The mattress keepers were all in place on the bed system. Once the bed rail was tightened, zone three was re-measured and passed. The interim ESM was asked to also measure other beds with similar loose bed rails in rooms B and C, and the beds passed zone three due to an extra firm mattress. The interim ESM reported that they had purchased and installed new mattresses for many beds and would replace the mattress on bed A as it was noted to be very soft.

According to the HC guidance document, bed rails that have more than one position (an intermediate or high and low locking positions) would need to be tested in each of the locked positions. According to the interim ESM, none of the bed systems that included bed rails that could be locked into more than one position, were tested in each position for entrapment zone three.

C) The bed systems in the home included four mattress keepers, one on each corner in order to keep the mattress from sliding side to side. When bed rails were

tight and mattress keepers were in place, no gaps were evident between the mattress and the bed rail in any locked position. Beds in resident rooms D and E did not have all four mattress keepers and each bed had bed rails applied, either in the transfer or the guard position. The bed in room D also had a very loose and unstable bed rail. The mattresses on both beds slid from side to side, opening up gaps between the bed rails and the mattress. Bed rails were also hand tested for stability on June 14, 2018, in resident rooms . F, G, H, I and J. The bed rails were all loose and unstable. The interim ESM was shown the beds in question and tightened all of the bed rails except for D, which did not remain tight. It was removed and replaced with another bed rail and re-measured and the mattress keeper replaced by the following day. The interim ESM reported to inspector #120 on June 14, 2018, that bed rails were routinely tightened and on a schedule, however some of the bed rail hardware (nuts, bolts etc.) could not be tightened, even after they were replaced with new hardware that was not supposed to self-loosen. The interim ESM, after being asked if he was aware of any of the above issues, said that he was not, that staff did not report any of the above identified issues to him or document them in their maintenance requisition system. The interim ESM reported to inspector #120 on June 25, 2018, that all of the beds had been re-measured with bed rails in the transfer position, tightened if required and broken or missing mattress keepers replaced.

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

2. The licensee has failed to ensure that where bed rails were used, that residents were assessed in accordance with prevailing practices, to minimize risk to the residents.

The prevailing practice identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada) was identified by the Ministry of Health and Long Term Care in 2012, and provides the necessary guidance in establishing a clinical assessment where bed rails are used. One main principle includes that the resident's right to participate in care planning and make choices be balanced with caregivers' responsibility to provide care according to an individual assessment,

professional standards of care, and any applicable laws and regulations.

During this follow up inspection, the conditions that were laid out in CO #003 were all met with the exception of requirement (1) related to the use of bed rail alternatives, and in part requirement (4) related to information for families, staff and residents.

According to the Associate Director of Care (ADOC), the process of assessing the residents in their bed systems included no bed rails upon admission for new residents to determine their bed mobility and transfer abilities. If the benefit outweighed the risks, bed rails would be installed. For residents who were admitted prior to October 2017, and who had bed rails in use, were re-assessed for bed rail needs and risks. However, in both situations, if the resident or their Substitute Decision Maker (SDM) refused any alternatives or the removal of bed rails, despite the risks identified, the bed rails remained on the beds without any further interventions (i.e. use of soft rails or a different type of rail). In these situations, according to the licensee's bed safety policy VII-E-10.20, the Director of Care or designate was required to communicate the risks to the SDM/resident, document the discussion and to determine the frequency of checks the resident would be monitored. The SDM or resident were required to sign a consent form agreeing to the use of the bed rails despite the bed rail risks identified. No further details were provided to guide the assessor in the policy in regard to mitigating the identified risks and what types of risks were predominant for that particular resident.

Discussion was held with both the interim Executive Director (ED) and the ADOC to re-iterate that the acquisition of a signed consent by an SDM or resident to bed rail risks without further interventions could not be accepted. The licensee was responsible for managing any identified risks with respect to their equipment. The regulatory requirement for medical devices such as bed rails which are also considered personal assistive service devices is that the devices be applied when the benefit outweighed the risk and that consent only be required when the interdisciplinary team decided that the resident's condition warranted a bed rail, that the benefits outweighed the risks and that bed rails were necessary to assist the resident with bed mobility or transfers. The SDM/resident would be given the choice at that time to accept the recommendations by signing a consent for their use. The process was identified to be in reverse in this case, where the SDM/resident was demanding that bed rails be applied or kept on the bed where the interdisciplinary team was opposed to the application of bed rails and the licensee was absolving themselves of the risks presented.

Five residents #005, #023, #024, #025, #028 were randomly selected during this inspection to determine if they were assessed for bed safety risks when bed rails were applied. All five residents were assessed for bed rail risks between March and June 2018, did not have any documentation made by an interdisciplinary team to determine what alternatives were trialled before applying one or more bed rails, the time frames the alternatives were trialled and whether they were successful or not and whether the bed rails being used by the residents posed any identified risks and if so, what interventions were implemented to mitigate those risks.

Residents #005, #024, #025, #028, three of which were observed in bed with both bed rails applied and according to their written plan of care and bed safety assessments, required extensive assistance with bed mobility, were not able to follow direction and were not able to use the bed rails independently. Each resident was identified by the assessor as at risk of potential bed related injury or entrapment. In each case, documentation in their clinical records included that the resident's SDM requested that bed rails be applied. RN #102 who completed resident #025's assessment stated that there were no mitigation strategies that could have been used to make the bed rails safer and that the SDM refused to allow the nursing staff to trial any alternatives. The RN stated that the SDM did not care about the risks despite the information provided.

The information fact sheet or pamphlet that was to be developed by the licensee regarding bed safety was not fully developed. According to the ADOC, some of the information required in CO #003 was added to a newsletter in May 2018 and disseminated to the family members. A copy of the newsletter was reviewed and included the benefits and risks/hazards of bed rail use, the role of both the SDM and licensee with respect to resident assessments, available alternatives to bed rails and how residents would be assessed upon admission, but was missing how bed systems are evaluated for entrapment zones and what prevailing practices and laws govern bed systems in Ontario.

The licensee, although completing a comprehensive assessment and identifying the resident's needs and whether a bed rail was contraindicated for the resident, did not follow through with ensuring that the bed system risks were mitigated or that alternatives were trialled when safety risks were identified. In referring back to the clinical assessment guide, the resident or SDM's right to participate in care planning and make choices should have been balanced with caregivers' responsibility to provide care according to an individual assessment, professional

standards of care, and any applicable laws and regulations. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

In 2017, resident #021 fell and sustained a laceration, was transferred to the hospital and received sutures to the area.

The home's policy "Skin and Wound Care Management Protocol", policy #VII-G-10.80 with a revised date of April 2016, directed staff to conduct a skin assessment with a resident exhibiting altered skin integrity.

The clinical record for resident #021 which did not contain a skin assessment using a clinically appropriate assessment instrument following the incident.

Registered Nurse (RN) #117 stated that an assessment was required to be completed at the time of the incident. The RN was not able to locate any skin/wound assessment related to the initial wound in the resident’s clinical record.

RN #117 acknowledged the staff failed to complete a skin/wound assessment using the home's clinically appropriate assessment instrument at the time of the incident. [s. 50. (2) (b) (i)]

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

In 2017, resident #021 fell and sustained a laceration, was transferred to hospital and received sutures to the area.

The home's policy "Skin and Wound Care Management Protocol", policy #VII-G-10.80 with a revised date of April 2016, directed staff that the Registered Dietitian(RD) complete an assessment of all residents who exhibited altered skin integrity.

The clinical record did not identify a referral to the RD or an assessment completed by the RD related to the laceration.

The RD stated there was no referral related to resident #021 laceration and therefore no dietary assessment was completed.

During an interview with the Interim DOC, they acknowledged the home had not referred resident #021 to the RD and a nutrition assessment was not completed. [s. 50. (2) (b) (iii)]

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

A) In 2017, resident #021 fell and sustained a laceration, was transferred to hospital and received sutures to the area.

The home's policy "Skin and Wound Care Management Protocol", policy #VII-G-10.80 with a revised date of April 2016, directed staff to initiate weekly skin assessment.

Resident #021's clinical record did not locate any weekly assessments for the laceration.

RN #117 acknowledged the home had not completed a weekly skin assessment as required.

B) Review of a complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) reported concerns about the home's care to resident #007 during a change in the resident's condition.

Interview with the complainant stated resident #007 became ill in 2018 and was transferred to the hospital upon the request of the resident's Substitute Decision Maker (SDM) and stated the resident was diagnosed with a medical condition. The complainant alleged that the resident had a skin integrity impairment caused by the medical condition and stated they were told by the home that the skin impairment was being treated but was not.

The LTCH inspector observed a skin integrity impairment to an area of the resident's body. RN #127, RN #119, Registered Practical Nurses (RPN) #121, and Personal Support Worker (PSW) #111 was informed by the inspector of their observation.

Review of the resident's Point Click Care (PCC) weekly skin assessments stated an initial skin assessment was completed for the skin integrity impairment but

further review did not show evidence that weekly assessments were completed consistently in the months of May and June 2018.

Interview with RPN #121, indicated that the resident had the skin impairment and a treatment that had been prescribed was discontinued. They indicated they did not think the skin impairment was a result of the resident's change in condition from earlier in the year. RN # 127 stated that it is the home's practice that when a resident has been identified with a skin impairment, the registered staff are to monitor the skin impairment weekly using the weekly assessment form in PCC.

Interviews with the interim DOC and Associate Director of Care (ADOC) acknowledged that the home's practice is for registered staff to monitor and assess the resident's skin impairment on a weekly basis.

C) During stage one of the Resident Quality Inspection (RQI), resident #011 was triggered as having a skin integrity impairment identified from a record review and a staff interview.

Review of resident #011's written care plan indicated the resident has an skin integrity impairment related to their medical conditions.

Interview with RPN #121 indicated resident #011 had a skin integrity impairment due to their body positioning. RPN #121 indicated that resident #011's skin integrity impairment had a treatment in place. The treatment was administered according to a schedule and that the skin integrity impairment was assessed and monitored for any changes, documented and reported to the physician for any significant changes.

Review of resident #011's PCC weekly skin assessments did not show evidence that a weekly skin assessment was completed for identified dates in December 2017 and January 2018. RN #127 acknowledged that #011's that weekly skin assessments were not completed for the identified dates.

Interview with the interim DOC and the Skin and Wound Lead acknowledged that a resident who has been identified with a skin integrity impairment is to be assessed on a weekly basis.

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed

at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was afforded privacy in treatment.

RPN #105 was observed administering an identified medication to resident #026 while the resident's room door was still open. Resident #026 acknowledged they wanted the door closed for the administration of the medication.

RPN #105 acknowledged that the door should have been closed for privacy when administering the medication to the resident.

The licensee failed to ensure that resident #026 was afforded privacy in treatment, specifically in the administration of an identified medication. [s. 3. (1) 8.]

2. The home failed to ensure that that the following rights of residents was fully respected and promoted: 11. Every resident has the right to iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

The LTCH inspector observed a Point of Care (POC) monitor screen on and left unattended which provided information about resident #029’s medical condition, resident #030, and #31's activities of daily living; and #033's personal health information as well as their required care needs for others nearby to be able to visualize.

RPN# 121, PSWs #129 and the interim DOC acknowledged that it is the home’s practice for staff to sign off and close the POC screen before leaving the area so that residents' personal health information as mentioned above would remain confidential. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure that the resident is afforded privacy in treatment;
-to ensure that that the following rights of residents are fully respected and promoted: 11. Every resident has the right to iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

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

In 2017, resident #021 fell and sustained a laceration. The resident was transferred to the hospital and returned with sutures to the laceration.

The home's policy "Falls Prevention", policy #VII-G-30.00, with a revised date of January 2015, directed staff to complete an initial post fall assessment and initiate head injury routine (HIR) if warranted and to update the resident's plan of care.

The LTCH Inspector reviewed the clinical record for resident #021 and did not locate any reassessments completed post fall in the progress notes or in the assessment tab.

During an interview RPN #118 and RN #117, both stated that once the resident was assessed for the initial fall, unless there was a head injury or unwitnessed fall when HIR would be implemented, there were no other post fall assessments to be completed.

During an interview with the interim DOC, they acknowledged the home does not include a reassessment instrument for the purposes of reassessing a resident after a fall as part of the falls prevention and management program.

B) In accordance with 49(1) The Falls Prevention and Management Program, must at a minimum, provide for strategies to reduce or mitigate falls, including monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment supplies, devices and assistive aids. O. Reg. 79/10, s. 49(1).

In 2017, resident #021 fell and sustained a laceration. The resident was transferred to the hospital and returned with sutures to the laceration.

The home's policy "Falls Prevention", policy #VII-G-30.00 with a revised date of January 2015, directed staff to complete a medication review to explore alternatives to medication that may increase the risk of falling.

The resident's clinical record did not include a medication review related to the fall and the risk of falls for resident #021.

RN #117 acknowledged the home had not initiated a medication review of the resident's drug regime as it related to the fall and risk of falls.

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

2. In accordance to Reg 79/10 114 (3) The written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Resident #019 returned from hospital on an identified date and according to the Electronic Medication Administration Record (E-MAR) for a particular month the resident's identified medication patch was signed off as applied for three identified dates.

A medication incident report was reviewed on an identified date indicating that resident #019 was found that day with the medication patches on the resident's body.
Another medication incident report was reviewed on an identified date indicating that resident #019 was found again with the medication patches on the resident's body.

The home's policy "High Alert Medication", Policy # 5-7, stated that the old patch is to be removed prior to applying a new one.The home's policy "Patch Disposal for Monitored Medication", Policy # 6-8, with a revised date of July 2017, stated that the nurse is to remove any used patches from the resident and place on Patch Disposal Record Sheet.

RPN #102 explained that the old patch must be removed from the resident's body prior to applying a new one.

The interim DOC acknowledged that in both incidences the old patch should have been removed prior to applying the new medication patch and that the high alert information sheet for identified medication patch should have been followed as per the policy.

The licensee failed to ensure the policy was followed on administration of an identified medication patches.. [s. 8. (1) (a)]

3. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee must ensure that procedures were developed and

implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

Resident #017 had informed LTCH Inspector #695 they were missing a piece of clothing and had informed a laundry aide. Resident #003 informed the LTCH Inspector they had been missing a bed item and that their family member had informed staff at the time.

During an interview with PSW #144 they told the LTCH Inspector that when a resident informs them they have a missing item, they would look in the resident's room and then the laundry room. If they were unable to locate the item, they completed a missing item form and gave it to the nurse. Staff also checked other resident rooms for the item(s).

During an interview with RN #101, they told the LTCH Inspector the completed missing item form was kept at the nurse's station for a day so that staff knew what to look for. If the item was not found on the unit(s), and it was then forwarded to the laundry department for them to look for the item.

The home's policy "Missing Clothing and Items", policy #VII-C-10.12 with a revised date of April 2016, directed staff to:
- complete the "Missing Clothing and Items" form when an item was reported missing,
- conduct a search of the resident room and area,
- report the lost item by forwarding the form to the laundry department and,
- file a copy of the completed "Missing Laundry and Items" form.

Laundry aide #143 was not aware of the policy or process related to their role in missing clothing/laundry.

The LTCH Inspector reviewed the completed missing laundry forms for the current calendar year as provided by the interim ESM.

Resident #017 and resident #003's items were not found to be in the forms provided.

The ESM acknowledged there were no forms completed for the two specific items.

4. The licensee has failed to ensure that their Missing Clothing and Items policy

was followed.

Resident #010's SDM reported that resident #010's personal belongings were missing for the last few months. The SDM reported that the home was unable to find the resident's personal belongings and that the resident had to pay for new ones.

RN #127 stated that a form is filled out every time a resident's personal item goes missing called Missing Clothing and Items Form.

The Resident Relations Coordinator (RRC) stated that resident #010 approached them regarding the missing personal belongings earlier in the year. RCC #135 stated that the Missing Clothing and Items Form was not filled out for the missing personal belongings.

The home's policy on Missing Clothing & Items Policy # VII-C-10.12, with a revised date of April 2016, stated that a Missing Clothing and Items Form should be filled out for items reported missing and should be submitted to the Environmental Service department.

The interim ESM confirmed that a Missing Clothing and Items Form was not submitted regarding resident #010's personal belongings.

The licensee failed to ensure that their Missing Clothing and Items policy on reporting missing items was implemented. [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 -Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system is (b) complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

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

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

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's vision.

Resident #005 was identified with visual impairment.

Resident #005's written care plan did not indicate a focus to address the resident's visual impairment.

Interviews with PSW #109 indicated that they were not aware that resident was visually impaired.

Interview with RN #119 confirmed that resident #005's was identified on the most recent Minimum Data Set (MDS) assessment as having a visual impairment and that the resident's care plan should have been updated to address it.

The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's visual impairment. [s. 26. (3) 4.]

2. The licensee failed to ensure the plan of care is based on an interdisciplinary assessment of the resident's activity patterns and pursuits.

Resident #017 expressed concerns regarding the activities in the home not meeting the resident's needs. The resident stated that often on the weekends there are two activities offered and that there are no activities that resident was interested in.

Recreation Therapy Aides (RTA) #114 and #115 indicated that every resident has an individualized interdisciplinary assessment of the resident's activity patterns and pursuits. This assessment was to be completed by the assigned recreation therapist and is located in the written plan of care for each resident.

RTA #116 acknowledged that they are assigned to assess resident #017 and complete their plan of care that included the resident's activity patterns and pursuits. RTA #116 acknowledged that this was not completed.

The DRP confirmed that resident #017's plan of care did not have the necessary assessments.

The licensee failed to ensure the plan of care for resident #017 was based on an interdisciplinary assessment of the resident's activity patterns and pursuits. [s. 26. (3) 16.]

3. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of sleep and rest patterns with respect to the resident.

a. Resident #019 triggered for being bedfast on the most recent MDS assessment.

The Inspector observed on June 6, and 11, 2018, the resident fully dressed and lying comfortably in their bed. When asked, the resident stated they wanted to be in bed.

PSW #103 stated the resident was not at end-of-life and that both the resident and their SDM preferred the resident to be dressed appropriately and to stay in the bed unless they requested otherwise.

The clinical record for resident #019 did not include the sleep and rest patterns for this resident.

RPN #102 and RN #101 acknowledged resident #019 did not have any sleep and rest patterns identified in their plan of care.

b. During stage two of the RQI, resident #005's was identified as being bed fast all or most of the time according to the most recent MDS assessment.

Resident #005's written plan of care last did not indicate a focus regarding the resident's sleep patterns and preferences.

RN # 119 confirmed that resident #005 does not have a care plan regarding their sleep patterns and preferences.

Interview with the DOC indicated that the only residents who have verbalized their sleep preferences would have a care plan and those that have no preferences will not.

The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of sleep and rest patterns with respect to the resident. [s. 26. (3) 21.]

4. The licensee failed to ensure the plan of care is based on an interdisciplinary assessment of the resident's cultural, spiritual, and religious preferences and age-related needs and preferences.

Resident # 017 expressed concerns regarding recreational and social activities in

the home.

RTA #116 acknowledged that this was not completed.

The DRP #131, who is the manager of the RTAs stated that it is expected that each resident has an individualized plan of care which includes an interdisciplinary assessment of the resident's cultural, spiritual, and religious preferences and age-related needs and preferences. DRP #131 acknowledged that resident #017's plan of care did not have the necessary assessments.

The licensee failed to ensure the plan of care for resident #017 was based on an interdisciplinary assessment of the resident's cultural, spiritual, and religious preferences and age-related needs and preferences. [s. 26. (3) 22.]

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 plan of care is based on an interdisciplinary assessment of the resident's vision;
- ensure the plan of care is based on an interdisciplinary assessment of the resident's activity patterns and pursuits;
- ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of sleep and rest patterns with respect to the resident;
-ensure the plan of care is based on an interdisciplinary assessment of the resident's cultural, spiritual, and religious preferences and age-related needs and preferences, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the annual program evaluation for falls prevention and management included the dates that changes to the program were implemented.

The LTCH Inspector reviewed the home's "Quality Management - LTC Program/Committee Evaluation Tool 2017 for falls prevention.

The written record listed a number of changes expected to be made to the falls prevention and management program but did not include the dates those changes were implemented.

During an interview with the interim DOC, they acknowledged the home had not included the dates the changes to the falls prevention program were implemented. [s. 30. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance - to ensure that the annual program evaluation for falls prevention and management included the dates that changes to the program is implemented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in a medication cart that was kept locked and secure.

On June 11, 2018, the LTCH Inspector observed RPN #105 leave the medication cart and entered a resident's room to administer the resident's medication. The medication cart, which was in the hallway, was left unlocked and was out of sight of the RPN.

The home's policy "The Medication Storage," Policy #3-4, with a revised date of January 2018, states that the medication carts should be locked at all times when note attended by registered staff.

The licensee failed to ensure that the medication cart where drugs were stored was kept locked at all times when not in use. [s. 130. 1.]

2. The licensee failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On June 21, 2018, at 1520 hrs, the LTCH Inspector went to an identified nursing station and found RTA #115 on the computer at the nursing station. There was a garbage bin that held the medication room door open at the nursing station and there were no registered staff inside or at the nursing station. The medication carts for two units were found in the medication room. At 1530 hrs, RPN #141 came back to the nursing station and acknowledged that the door of the medication room should have been kept locked when registered staff were not present.

The licensee failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure that drugs are stored in a medication cart that are kept locked and secure;
- to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure a written record was kept relating to an evaluation of the Infection Prevention and Control (IPAC) program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During a review of the Infection Prevention and Control program, the LTCH Inspector reviewed the home's "Quality Management – LTC Program/Committee Evaluation Tool" for Infection Prevention and Control.

The evaluation tool dated February 28, 2018, reviewed the calendar year 2017.

The document did not include any changes made to the IPAC program as a result

of the evaluation or the dates any changes were made to the program.

The interim DOC acknowledged the annual review of the IPAC program did not include any changes made to the program or dates any changes were implemented. [s. 229. (2) (e)]

2. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

On June 5, 2018, LTCH Inspector observed resident #021's room with an infection control precaution sign on the door, no residents were in the room, the door was in an open position and a circulating fan on at the far side of the room.

RN #100 stated that resident #021 was on infection control precautions due to an identified infection. When asked the location of the resident at that time, the RN stated they must be in the dining room for lunch however, they should have been given tray service in their room during the precautionary period.

Resident #021 was placed on the home area's "Infection Control Surveillance Record" with an identified infection. The clinical record review identified the resident as having two symptoms and were documented as starting on an identified date.

During an interview with PSW #140, they told the LTCH Inspector when a resident was on isolation for an infection control precautions, the residents have their meals served in their rooms.

The home's policy "Disease Protocols - Required Level of Precautions Based Upon Clinical Syndromes and Conditions", policy # IX-H-10.00 with a revised date of January 2015, directed staff to implement droplet and contact precautions for respiratory infections.

The home's policy "Droplet Precautions" - policy #IX-G-10.70 (c) directed that the resident on droplet precautions was to wear a surgical grade mask when leaving their room and to ensure single use equipment was implemented.

The RN and the LTCH Inspector observed the resident in the dining room, sitting at a dining table with two other residents. The resident was not wearing a protective face mask.

The LTCH Inspector interviewed resident #021 who said they continued to have symptoms of infection and was observed to have those symptoms while at the dining table.

RN #100 acknowledged the resident was on infection control precautions and was not to have been taken to the dining room.

The RPN acknowledged that staff did not implement the infection prevention and control practices. [s. 229. (4)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #010 was offered an annual dental assessment and other preventive dental services.

Resident #010's SDM expressed concern regarding resident #010's oral care especially since their dental prosthesis have been missing for the past few months.

DRP #131 explained that the dental service provider will contact the resident or substitute decision maker directly to offer dental services for upcoming visits.

Communication sent from dental service provider to the DRP stated that the resident refused services on an identified date and was never contacted again.

The DRP acknowledged that there was no evidence of resident #010 being offered dental services in 2017, including and up to when communication was sent from dental service provider on an identified date.

The licensee failed to ensure that resident #011 was offered an annual dental assessment and other preventive dental services. [s. 34. (1) (c)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that when Resident's Council had advised the licensee of concerns or recommendations that a written response was provided to the Resident's Council within ten days of receiving the advice.

The LTCH Inspector reviewed the minutes of the Resident's Council (RC) for the period of November 2017 up to and including March, April, and May 2018 following the interview with the President of RC who stated they do not receive written responses to the concerns brought forth from the RC.

The minutes for November and December 2017 and January, February, and March 2018, contained repeated concerns related to maintenance, housekeeping, dietary, and staff conduct.

The home's policy "Resident's Council", policy #X-B-10.00 with a revised date of August 2015, directed that the DRP distribute the concerns to the appropriate department head following a meeting of RC, the department head was to respond in writing within five days and submit the response to the Executive Director who was to respond in writing within ten days of receiving the advice from the RC.

In May 2018, the RC presented a concern regarding the home's maintenance, housekeeping, dietary, and staff conduct.

During an interview with the DRP, they stated they had forwarded the concern forms to Nursing, Environmental Services and Dietary Services following the May 2018 RC meeting. They stated that dietary and environmental services had not responded as of the interview date.

During an interview with the Director of Dietary Services (DDS), they stated they had not responded to the most recent complaint and was not aware of the specific residents who complained about dietary concerns.

During an interview with the Interim ESM who was not aware of the concern regarding the maintenance and housekeeping issues and had not responded to RC within ten days.

The DRP acknowledged the home had not responded within ten days of receiving three complaints/concerns from RC. [s. 57. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the residents substitute decision maker (SDM) was notified of the results of the alleged abuse immediately upon the completion of the investigation.

A CI was received related to resident #010 who reported that during the morning of an identified date, they were physically assaulted by a staff member during the an identified time. An investigation was completed by the home and the outcome was that there was no evidence of the alleged physical abuse. The interim DOC explained in an interview that resident #010's room was changed because the trigger for the incident was believed to be a sleep disturbance. The CI indicated that an identified individual was the SDM for the resident and that they were notified about the alleged physical abuse.

In stage one of the RQI an interview was completed with resident #010's SDM, they stated that resident #010 reported being physically assaulted by a staff member and that they were never informed by the home.

In an interview with the interim DOC #138, they stated that the investigation was completed. The interim DOC explained that the SDM visited one day and inquired about the room change and that this was the day resident # 010's SDM was informed about the outcome of the investigation. The interim DOC stated that they do not recall which day the SDM visited or whether it was before or after the investigation was completed. The DOC could not find documentation of the SDM being notified of the results of the investigation.

The progress notes stated that resident #010's SDM was upset that they were not notified regarding the resident's room change.

The licensee failed to ensure that resident #010's SDM was notified of the results of the alleged abuse immediately upon the completion of the investigation. [s. 97. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included the analysis and follow-up of long-term actions planned to correct the situation and prevent recurrence.

A CI was received related to resident #010 reporting that during the morning of an identified date, that they were physically assaulted by a staff member during an identified time. The resident was assessed by the attending physician and there was no injury noted to the resident.

The police were contacted and the incident report stated that no charges were laid. An investigation occurred including interviews with the resident and staff members who worked the identified time and the outcome was that there was no evidence of the alleged abuse.

RPN #143 stated that the resident was upset because they were disturbed by staff who had turned on the lights to provide care to one of resident #010's roommate. The RPN explained that the plan was to transfer resident #010 to another room where the roommates did not require assistance at night in order to minimize sleep disturbances for the resident.

The interim DOC explained that resident #010's room was changed as a result of the incident because it was determined that turning on the light was the trigger for what happened that night. The interim DOC admitted that the analysis and long-term action of switching the residents' room was not included in the critical incident report submitted to the Director.

The licensee failed to ensure that the report to the Director included the analysis and long-term follow up action of changing the room for resident #010. [s. 104. (1) 4.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

i. a breakdown or failure of the security system,

ii. a breakdown of major equipment or a system in the home,

iii. a loss of essential services, or

iv. flooding.

O. Reg. 79/10, s. 107 (3).

3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

According to the Long Term Care Homes Act, 2007, Ontario Regulation 79/10, the definition of significant change means a major change in the resident's health condition that,
a) will not resolve on it's own
b) impacted on more than one aspect of the resident's health condition, and
c) required an assessment by the interdisciplinary team or a revision to the resident's plan of care.

In 2017, resident #021 fell and sustained a laceration, was transferred to hospital and received sutures to the area and returned back to the home the same day.

Upon return from the hospital the resident had altered skin integrity, pain in their injury site, and other areas related to the fall that required analgesia and were placed on head injury routine to monitor any neurological changes as a result of the fall.

The sutures required manual removal after a period of time. Resident #021's fall risk increased to a higher score within the moderate range according to the post fall risk assessment.

During an interview with the interim DOC, they told the LTCH Inspector they did not believe that resident #021 met the significant change in condition criterion and therefore did not submit a report to the Director. [s. 107. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee failed to ensure that the records of the residents of the home were kept at the home.

In Reg. 79/10, s. 34(1), it is stated that every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Resident #011's dental records were reviewed.

The Director of Resident Programs #131 acknowledged responsibility for coordinating dental care services through Direct Dentistry Services for the residents in the home. The DRP explained that Direct Dentistry contacted residents or their substitute decision maker directly to offer dental services for upcoming visits.

Communication from Direct Dentistry to the DRP #131 on an identified date, regarding resident #011 stated that the notes from the residents contacted for their December 2017, visit were discarded.

LTCH Inspector #695 reviewed residents' paper chart and could not find documentation of whether resident #011 received dental services.

The DRP #131 explained that Direct Dentistry Services discarded all records of contact with residents offered dental services in 2017 and there were no records kept in the home unless the resident received the service.

The licensee failed to ensure that the records of the residents of the home were kept at the home. [s. 232.]

Issued on this 31 day of August 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

Central West Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by JANET GROUX (606) - (A1)

Inspection No. / No de l'inspection : 2018_723606_0014 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 011627-18 (A1)

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

Report Date(s) / Date(s) du Rapport : Aug 31, 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)

Linked to Existing Order / Lien vers ordre existant: 2017_561583_0018, CO #003;

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

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

Specifically, the licensee must complete the following;

1. All residents who currently use one or more bed rails and were previously assessed by an interdisciplinary team to be at risk for a bed-related injury, shall have an alternative to bed rails trialled. Within the resident's clinical record, documentation shall be made as to the type of alternative trialled, the dates trialled and the outcome of the trial.
2. Any resident or SDM shall consent to a bed rail application only after all efforts have been made to trial various types of alternatives or interventions available and/or the specific risks mitigated that were identified during the sleep observation period.
3. The interdisciplinary team shall be made aware of the types of accessories or products that are available to mitigate certain types of risks associated with bed rail use. For bed rails with suspension risks, the team shall be made aware of alternative types of bed systems or bed rails that can be applied that do not include a suspension risk. [The bed manufacture can be contacted to determine if the current rotating assist rails can be replaced with quarter rails at the head of the bed that do not rotate].
4. Accessories that have been added to a resident's bed where one or more bed rails are in use and a therapeutic mattress failed zones 2, 3 or 4, shall be applied correctly, so that it remains in place in order to mitigate the zones that failed.
5. Develop a fact sheet or pamphlet for families, staff and residents, that can be disseminated that includes information that was posted in the home's May 2018 newsletter in addition to the law governing adult hospital beds in Ontario, basic information about how beds pass or fail entrapment and references or links to Health Canada and the MOHLTC Action Line.

Grounds / Motifs :

1. The licensee failed to comply with Compliance Order #003 from inspection #2017-561583-0018 served on December 11, 2017, with a compliance due date of June 1, 2018.

The licensee was ordered to 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.

The licensee completed requirements #2, #3, #5 and #6 but failed to fully complete requirements #1 related to the use of bed rail alternatives and #4 related to information for families, staff and residents.

The licensee has failed to ensure that where bed rails were used, that residents were assessed in accordance with prevailing practices, to minimize risk to the residents.

The prevailing practice identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada) was identified by the Ministry of Health and Long Term Care in 2012, and provides the necessary guidance in establishing a clinical assessment where bed rails are used. Two principles include (1) that the resident's right to participate in care planning and make choices should be balanced with caregivers' responsibility to provide care according to an individual assessment, professional standards of care, and any applicable laws and regulations.

An inspection was previously conducted October 5-18, 2017, which identified noncompliance with the bed safety program and a compliance order (CO) #003 was issued on December 11, 2017, with a compliance due date of June 1, 2018.

During this follow up inspection, the conditions that were laid out in CO #003 were all met with the exception of requirement (1) related to the use of bed rail alternatives, and in part requirement (4) related to information for families, staff and residents.

According to the Associate Director of Care (ADOC), the process of assessing the residents in their bed systems included no bed rails upon admission for new residents to determine their bed mobility and transfer abilities. If the benefit outweighed the risks, bed rails would be installed. For residents who were admitted prior to October 2017, and who had bed rails in use, were re-assessed for bed rail needs and risks. However, in both situations, if the resident or their substitute decision maker (SDM) refused any alternatives or the removal of bed rails, despite the risks identified, the bed rails remained on the beds without any further interventions (i.e. use of soft rails or a different type of rail). In these situations, according to the licensee's bed safety policy VII-E-10.20, the Director of Care or designate was required to communicate the risks to the SDM/resident, document the discussion and to determine the frequency of checks the resident would be

monitored. The SDM or resident were required to sign a consent form agreeing to the use of the bed rails despite the bed rail risks identified. No further details were provided to guide the assessor in the policy in regard to mitigating the identified risks and what types of risks were predominant for that particular resident.

Discussion was held with both the interim Executive Director and the ADOC to re-iterate that the acquisition of a signed consent by an SDM or resident to bed rail risks without further interventions could not be accepted. The licensee was responsible for managing any identified risks with respect to their equipment. The regulatory requirement for medical devices such as bed rails which are also considered personal assistive service devices is that the devices be applied when the benefit outweighed the risk and that consent only be required when the interdisciplinary team decided that the resident's condition warranted a bed rail, that the benefits outweighed the risks and that bed rails were necessary to assist the resident with bed mobility or transfers. The SDM/resident would be given the choice at that time to accept the recommendations by signing a consent for their use. The process was identified to be in reverse in this case, where the SDM/resident was demanding that bed rails be applied or kept on the bed where the interdisciplinary team was opposed to the application of bed rails and the licensee was absolving themselves of the risks presented.

Five residents (#005, #023, #024, #025, #028) were randomly selected during this inspection to determine if they were assessed for bed safety risks when bed rails were applied. All five residents, were assessed for bed rail risks between March and June, 2018, did not have any documentation made by an interdisciplinary team to determine what alternatives were trialled before applying one or more bed rails, the time frames the alternatives were trialled and whether they were successful or not and whether the bed rails being used by the residents posed any identified risks and if so, what interventions were implemented to mitigate those risks.

Residents #005, #024, #025, #028, three of which were observed in bed with both bed rails applied on June 14, 2018, and according to their written plan of care and bed safety assessments, required extensive assistance with bed mobility, were not able to follow direction and were not able to use the bed rails independently. Each resident was identified by the assessor as at risk of potential bed related injury or entrapment. In each case, documentation in their clinical records included that the resident's SDM requested that bed rails be applied. RN #102 who completed resident #025's assessment stated that there were no mitigation strategies that could

have been used to make the bed rails safer and that the SDM refused to allow the nursing staff to trial any alternatives. The RN stated that the SDM did not care about the risks despite the information provided.

The information fact sheet or pamphlet that was to be developed by the licensee regarding bed safety was not fully developed. According to the ADOC, some of the information required in CO #003 was added to a newsletter in May 2018 and disseminated to the family members. A copy of the newsletter was reviewed and included the benefits and risks/hazards of bed rail use, the role of both the SDM and licensee with respect to resident assessments, available alternatives to bed rails and how residents would be assessed upon admission, but was missing how bed systems are evaluated for entrapment zones and what prevailing practices and laws govern bed systems in Ontario.

The licensee, although completing a comprehensive assessment and identifying the resident's needs and whether a bed rail was contraindicated for the resident, did not follow through with ensuring that the bed system risks were mitigated or that alternatives were trialled when safety risks were identified. In referring back to the clinical assessment guide, the resident or SDM's right to participate in care planning and make choices should have been balanced with caregivers' responsibility to provide care according to an individual assessment, professional standards of care, and any applicable laws and regulations.

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

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

between the mattress and the bed rail.

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

A) The acting Environmental Services Manager (ESM) and maintenance person confirmed that an approved weighted cone and cylinder tool was used to complete their bed system evaluation for entrapment zones one through four of all resident bed systems in April 2018. All of the bed systems passed all four zones of entrapment, with the exception of eight beds with therapeutic mattresses. The residents using these beds were provided with triangular shaped foam accessories that were designed to be wedged in between the bed rail and the mattress (zone three). However, during the inspection on June 14, 2018, the accessories were found to be sitting on top of the therapeutic mattresses, next to the bed rails that were seen in either the guard position (horizontal) or the transfer position (vertical), whether residents were in bed or not. The covering on the accessory was made of cotton or polyester and when stuffed into zone three by inspector #120, the accessory slid out of position. The purpose of the accessory was to mitigate any risks associated with zone three gaps, to fill the void to prevent a limb from sliding down into that zone and getting entrapped. The accessories therefore did not serve any particular purpose and could easily fall off the bed or be removed.

B) The bed rails on the bed frames were designed to rotate into more than one position. When in the highest or vertical position (transfer or assist position) the bed rails in resident rooms #59-1 appeared to have a larger than normal space between the bed rail and the side of the mattress. When the acting ESM was requested to measure the zone between the mattress and the bed rail while in the transfer position using the weighted tool, zone three did not pass entrapment. The mattress keepers were all in place on the bed system. Once the bed rail was tightened, zone three was re-measured and passed. The acting ESM was asked to also measure other beds with similar loose bed rails in rooms #53 and #55, and the beds passed zone three due to an extra firm mattress. The acting ESM reported that they had purchased and installed new mattresses for many beds and would replace the mattress on bed #59-1 as it was noted to be very soft.

According to the HC guidance document, bed rails that have more than one position (an intermediate or high and low locking positions) would need to be tested in each of the locked positions. According to the acting ESM, none of the bed systems that included bed rails that could be locked into more than one position, were tested in each position for entrapment zone three.

C) The bed systems in the home included four mattress keepers, one on each corner in order to keep the mattress from sliding side to side. When bed rails were tight and mattress keepers were in place, no gaps were evident between the mattress and the bed rail in any locked position. Beds in resident rooms #66-2 and #45-2 did not have all four mattress keepers and each bed had bed rails applied, either in the transfer or the guard position. The bed in room #66-2 also had a very loose and unstable bed rail. The mattresses on both beds slid from side to side, opening up gaps between the bed rails and the mattress. Bed rails were also hand tested for stability on June 14, 2018, in resident rooms #38, #50, #53, #55-2, 59. The bed rails were all loose and unstable. The acting ESM was shown the beds in question and tightened all of the bed rails except for #66-2, which did not remain tight. It was removed and replaced with another bed rail and re-measured and the mattress keeper replaced by the following day. The acting ESM reported to inspector #120 on June 14, 2018, that bed rails were routinely tightened and on a schedule, however some of the bed rail hardware (nuts, bolts etc.) could not be tightened, even after they were replaced with new hardware that was not supposed to self-loosen. The acting ESM, after being asked if he was aware of any of the above issues, said that he was not, that staff did not report any of the above identified issues to him or document them in their maintenance requisition system. The acting ESM reported to inspector #120 on June 25, 2018, that all of the beds had been re-measured with bed rails in the transfer position, tightened if required and broken or missing mattress keepers replaced.

The concerns related to the above noted bed system hazards and potential for resident risk were raised with the acting administrator and associate director of care during the inspection on June 15, 2018, and options discussed, as identified in the document "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment.

This order is based upon three factors where there has been a finding of non-compliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include severity, scope and history of non-compliance. In relation to s. 15(1) of Ontario

Regulation 79/10, the severity of the non-compliance was a level 2 as there was a potential to cause harm to residents related to bed safety concerns. The scope of the non-compliance was a level 3 as three out of three residents who used one or more bed rails were not assessed in accordance with prevailing practices. The history of non-compliance was a level 4 as the non-compliance was on-going with the this section that included; A Compliance Order #003 issued December 11, 2017, with a compliance due date of June 1, 2018 (2017-561583-0018)

(120)

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

Nov 29, 2018

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

(A1)
The licensee must be compliant with O. Reg. 79/10, r. 50 (2) (iv).

Specifically, the licensee shall ensure that residents #021, and #011, and any other resident, who has been identified with a skin integrity impairment is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

(A1)
Ground #1 has been removed.

2. During stage one of the Resident Quality Inspection (RQI), resident #011 was triggered as having a skin integrity impairment as identified from a record review and a staff interview.

Review of resident #011's written care plan revised stated the resident had a skin integrity impairment related to their medical issues.

Interview with RPN #121 indicated resident #011 had a skin integrity impairment due to their body positioning. RPN #121 indicated that resident #011's skin integrity impairment had a treatment in place. The treatment was administered every three days and that the skin impairment was assessed and monitored for any changes, documented and reported to the physician for any significant changes.

Review of resident #011's PCC weekly skin assessments of the resident's skin impairment did not show evidence that a weekly skin assessment was completed for the identified dates.

Interview with the interim DOC and the ADOC, the home's Skin and Wound lead acknowledged that a resident who has been identified with a skin integrity impairment is to be assessed on a weekly basis.

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered staff.

(606)

3. In July 2017, resident #021 fell and sustained a laceration, was transferred to hospital and received sutures to the area.

The home's policy "Skin and Wound Care Management Protocol", policy #VII-G-10.80 with a revised date of April 2016, directed staff to initiate weekly skin assessment.

Resident #021's clinical record and did not include any weekly assessments for the laceration.

RN #117 acknowledged the home had not completed a weekly skin assessment as required.

This order is based upon three factors where there has been a finding of non-compliance in keeping with r. 50 (2) (b) (iv) of Ontario Regulation 79/10. The factors include severity, scope and history of non-compliance. In relation to r. 50 (2) (b) (iv) of Ontario Regulation 79/10, the severity of the non-compliance was a level 2 as there was a potential to cause actual harm to residents. The scope of the non-compliance was a level 2 was patterned involving 3 out of 4 residents. The history of non-compliance was a level 4 as the non-compliance was on-going with this section of the LTCH that included a Voluntary Plan of Correction issued April 21, 2017 (#2017-546585_0003). (640)

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

Sep 30, 2018(A1)

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

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

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 31 day of August 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JANET GROUX - (A1)

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

Service Area Office / Bureau régional de services : Central West