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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 6, Feb 27, 2017	2017_561583_0002	034767-16	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF SANDALWOOD PARK
425 Great Lakes Drive BRAMPTON ON L6R 2W8

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

KELLY HAYES (583), IRENE SCHMIDT (510a), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 5, 6, 9, 10, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 2017.

The following inspections were conducted simultaneously with this Resident Quality Inspection: Complaint Inspection log #012171-16, related to personal care. Critical Incident Inspection log #033132-15, related to resident to resident responsive behaviours; log #033408-15, related to an unsafe transfer; 012008-16, related to falls prevention management; log #020391-16, related to responsive behaviours; log #022905-16, related to alleged staff to resident abuse; log #025407-16, related to alleged staff to resident abuse; log #027398-16, related to alleged staff to resident abuse; log #028188-16, related to alleged staff to resident abuse; log #029030-16, related to falls prevention management; log #032027-16, related to alleged staff to resident abuse; log #032491-16, related to resident to resident abuse; log #033713-16, related to falls prevention management; log #034592-16, related to to resident to resident abuse; log #035192-16, related to resident to resident abuse; log #001100-17, related to resident to resident abuse. Follow Up Inspection log #006065-16, related to bed rails.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing Care (DNC), Resident Assessment Instrument/Quality Improvement (RAI/QI) lead, Director of Environmental Services (DES), Kinesiologist, Director of Recreation, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW), families, and residents. During the course of the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures and resident health records and conducted interviews.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
5 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 23.	CO #901	2017_561583_0002	583

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use all equipment and devices in the home in accordance with manufacturers' instructions.

During an observation of the spa room on Cumberland unit, Elliott unit, and Johnston unit it was observed that the Alenti Lift and Hygiene Chair had no safety belt. In an interview with staff #600 and #601 it was shared that they were not aware belts were required when using the Alenti Lift and Hygiene Chair. In an interview with registered staff #603 it was shared that they did not know that a belt was required when using the Alenti Lift and Hygiene Chair. In interview with the Director of Nursing Care (DNC) it was confirmed that there were no safety belts or manufacture's instructions available in the home for the Alenti Lift chairs. A review of the bath schedule on Cumberland unit, Elliott unit, and Johnston unit identified there were residents whose preference was to receive a bath.

The "Alenti Instructions for Use, Arjohuntleigh Gentinge Group" dated May 5, 2016, identified the safety belt was to be used at all times. A warning in the manufacturer instructions stated, "To avoid falling, make sure that the patient is positioned correctly and that the safety belt is being used, properly fastened and tightened".

In an interview with the DNC it was confirmed that no safety belts were available and staff did not know the safety requirements for the use of the Alenti Lift and Hygiene Chair. On January 6, 2017, the DNC removed the Alenti Lift and Hygiene Chairs from the spa rooms and put them out of service. The DNC shared the chairs would be pulled from use until safety belts were ordered and received and staff received education on the Alenti Lift and Hygiene Chair and application of the safety belt. [s. 23.]

Additional Required Actions:

CO # - 901 was served on the licensee. CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the residents were assessed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

1. On January 19, 2017, the DNC confirmed that the Licensee had not developed a comprehensive bed safety assessment tool using 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 2013) recommended as the prevailing practice for individual resident assessments of bed rails by Health Canada. Following the issuing of a compliance order related to the use of bed rails, served on the Licensee on May 16, 2016, residents were assessed using the “Bed Rail Assessment/Algorithm” that the DOC confirmed was the only tool available at the time the assessments were completed. The “Bed Rail Assessment/Algorithm” was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails. Nine of nine residents reviewed were not assessed for the safe use of bed rails in accordance with the guidance document.

2. Documentation provided by the home at the time of this inspection indicated that the last “Bed Entrapment” audit was completed by the Director of Environmental Services (DES) on January 5, 2017 and at that time all bed systems were identified as having passed all entrapment zone testing. The DNC and the DES confirmed that they were aware of issues related to mattress compatibility with some of the bed frames used in the

home. The “Bed Entrapment” audit provided by the home indicated that for 28 of the 119 beds audited notations were entered on the audit that indicated “long mattress-Need 76” which was confirmed to mean that the mattresses currently on those beds were not compatible with the bed frames they were placed on. The DES confirmed that staff had been instructed to pull the fitted bottom sheet over the mattress keepers at the bottom of the bed as a way to keep the mattress within the mattress keepers and prevent potential risks for entrapment. Although there was a plan in place to purchase new mattresses, actions had not been taken to monitor those bed systems that had been identified as having incompatible mattresses and during this inspection six of nine bed systems reviewed were found to not have the mattresses contained within the mattresses keepers allowing the mattress to slide easily from side to side on the bed deck causing a potential entrapment risk between the mattress edge and the bed rails that were noted to be on those beds.

3. The following observations and the review of clinical records confirmed that residents were not assessed in accordance with expectations contained in the guidance document and actions were not taken to minimize the risk of bed entrapment between mattress edges and bed rails:

A) Resident #300 was noted to be in bed lying on a specified mattress and there were two specified types of bed rails attached to the bed on an identified date in January 2017. The resident’s plan of care plan indicated that the resident was to have two bed rails up when in bed and the resident was able to lower the bed rails themselves. The home provided the bed rail assessment that was completed on an identified date in May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

B) Resident #301 was noted to be in bed lying on a specified mattress and there were two specified types of bed rails, without additional specified bed safety interventions, in the up position on an identified date in January 2017. The resident’s plan of care indicated that the bed rails were used for Activities of Daily Living (ADL) support and the resident would hold onto the bed rails during positioning. The home provided the bed rail assessment that was completed on an identified date in May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails. Observations made on an identified date in January 2017 and confirmed by the Administrator, DNC and the DES confirmed that the resident was at risk related to bed entrapment when the specified type of mattress, which posed a risk of entrapment between the bed rail and the

mattress/ bed deck. At the time this observation was made the DES confirmed that the specified mattress and mattress equipment was not functioning properly.

C) Resident #302 was noted to be in bed lying on a specified mattress without additional specified bed safety interventions and there were two specified bed rails, in the up position on a specified date in January 2017. The resident's plan of care indicated that the bed rails were for ADL support and the resident was able to hold onto the side rails while being repositioned. The home provided the bed rail assessment that was completed on a specified date in May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

D) Resident #303's bed system was observed on a specified date in January 2017, when it was noted that the bed was equipped with two specified bed rails and the bed frame was equipped with hard plastic mattress keepers. At the time of the observation it was noted that the mattress was not contained within the mattress keepers and moved easily from side to side on the bed deck which created a potential risk of entrapment for this resident between the mattress edge and the bed rails. The resident's plan of care indicated that the resident was independent with bed mobility, two specified bed rails were used for independence with repositioning and the resident was at moderate risk for bed entrapment. The plan of care did not contain any directions to staff related to the actions to take to minimize the risk of entrapment that had been identified. The home provided the bed rail assessment that was completed on an identified date in December 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

E) Resident #304's bed system was observed on a specified date January 2017, when it was noted that the bed was equipped with two specified bed rails, one bed rails was in the up position and the bed frame was equipped with hard plastic mattress keepers. At the time of this observation the bottom of the mattress was not maintained within the mattress keepers and moved easily from side to side on the bed deck which created a potential risk of entrapment for this resident between the mattress edge and the bed rails. This was confirmed on an identified date January 2017, by the Administrator, DNC and DES during observations made on this date. The resident's plan of care indicated that two specified bed rails were used to assist with ADLs related to repositioning and transfers in and out of bed. The home provided the bed rail assessment that was completed on an identified date May 2016. This assessment was not based on the

guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

F) Resident #305's bed system was observed on an identified date in January 2017 and it was noted that the resident was in bed, the bed was equipped with hard plastic mattress keepers and there were two specified bed rails in the up position on both sides of the bed. At the time of this observation the mattress was not contained within the mattress keepers which created a potential entrapment risk for this resident between the mattress edge and the bed rails. This was confirmed on an identified date in January 2017, by the Administrator, DNC and DES during observations made on this date. The resident's plan of care indicated that the resident was able to hold onto the bed rails, needed total assistance of two staff for repositioning and the bed rails were used to assist with ADLs. The home provided the bed rail assessment that was completed on an identified date in May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

G) Resident # 306's bed system was observed on an identified date in January 2017 and it was noted that the bed was equipped with hard plastic mattress keepers and two specified bed rails were noted to be attached to the bed frame. At the time of this observation it was noted that the mattress was not maintained within the mattress keeps and the mattress moved easily from side to side on the bed deck creating a potential entrapment risk for this resident between the mattress edge and the bed rail. This was confirmed on January 20, 2017 by the Administrator, DNC and DES during observations made on this date. The resident's plan of care indicated that the resident would hold onto the bed rails and independently transfer self from side to side. The home provided the bed rail assessment that was completed on an identified date in May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

H) Resident #307's bed system was observed on an identified date January 2017 and it was noted that the bed was equipped hard plastic mattress keepers and two specified bed rails. At the time of this observation it was noted that the mattress was not maintained within the mattress keepers and the mattress moved easily from side to side on the bed deck creating a potential entrapment risk for this resident between the mattress edge and the bed rail. This was confirmed on an identified date in January 2017, by the Administrator, DNC and DES during observations made on this date. The resident's plan of care indicated the bed rails where to assist with ADLs and the resident

would hold onto the bed rails during repositioning. The home provided three bed rail assessment completed on an identified date in May 2016 and one bed rail assessment completed on an identified date in November 2016. These assessments were not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

l) Resident #308's bed system was observed on an identified date January 2017 and it was noted that the bed was equipped with hard plastic mattress keepers and two specified bed rails on both sides of the bed. At the time of this observation it was noted that the mattress was not maintained within the mattress keepers and the mattress moved easily from side to side on the deck creating a potential entrapment risk for this resident between the mattress edge and the bed rails. This was confirmed on an identified date in January 2017, by the Administrator, DNC and DES during observations made on this date. The resident's plan of care indicated the resident was able to independently reposition themselves from side to side using the bed rails. The home provided the bed rail assessment that was completed on an identified date in May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails. [s. 15. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 residents exhibiting altered skin integrity, including, 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 is specifically designed for skin and wound.

A) Resident # 003 was identified as having two alterations in skin that were not assessed by a member of the registered nursing staff. The DNC confirmed and information documented on Minimum Data Set (MDS) completed on an identified dates in May 2016, September 2016 and November 2016 which identified that resident #003 had alterations in their skin integrity on specified areas. The DNC and the clinical record confirmed at the time of this inspection that the home was unable to locate documentation in the resident's clinical record to verify that these changes in the resident's skin integrity were assessed using a clinically appropriate assessment instrument by a member of the registered nursing staff when they were identified.

B) Resident #006 was identified as having two areas of altered skin that were not assessed by a member of the registered nursing staff. Registered staff #604 confirmed and information documented on the MDS completed on an identified date in October 2016, identified that the resident had two areas of altered skin on an identified area as well as a progress note written on an identified date in October 2016, identified that the

resident had a third area of altered skin. Registered staff #604 confirmed that at the time of this inspection they were unable to locate any documentation in the resident’s clinical record to verify that these changes in the resident’s skin integrity were assessed using a clinically appropriate assessment tool by a member of the registered nursing staff when they were identified.

C) Resident #007 was identified as having two areas of altered skin that were not assessed by a member of the registered staff. Registered staff #604 and clinical documentation confirmed and information documented on the MDS completed in June 2016, September 2016 and December 2016, identified the resident had two areas of altered skin integrity on an identified area. Registered staff #604 confirmed that at the time of this inspection they were unable to locate any documentation in the resident’s clinical record to verify that these changes in the resident’s skin integrity were assessed using a clinically appropriate assessment instrument by a member of the registered nursing staff when they were first identified. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that residents exhibiting altered skin integrity, including, pressure ulcers, skin tears or wounds is assessment by a Registered Dietitian who is a member of the staff of the home and any changes made to the resident’s plan of care relating to nutrition and hydration were implemented.

A) Resident #006 was identified as having two areas of altered skin integrity, this resident was not assessed by the Registered Dietitian (RD). Registered staff #604 confirmed that at the time of this inspection they were unable to locate any documentation to indicate that a RD had assessed the resident related to changes in the resident’s skin integrity.

B) Resident #007 was identified as having two areas of altered skin integrity and this resident was not assessed by a RD. Information documented in the clinical record on identified dates in June, September and December 2016, identified the resident had two areas of altered skin integrity. Staff #604 confirmed that at the time of this inspection they were unable to locate any documentation to indicate that a RD had assessed the resident related to the above noted changes in the resident’s skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that residents exhibiting altered skin integrity, including, pressure ulcers, skin tears or wounds were reassessed using a using a clinically appropriate assessment instrument at least weekly by a member of the registered

nursing staff.

A) Clinical documentation confirmed resident #003 was identified in May 2016, as having an area of altered skin integrity. In September 2016 a second area of altered skin integrity was identified and in November 2016 a third area of altered skin integrity was identified. The DNC confirmed at the time of this inspection they were unable to provide documentation that these areas of skin breakdown were assessed weekly by a member of the registered nursing staff.

B) Clinical documentation for resident #006 on identified dates in October 2016 confirmed the resident had three areas of altered skin integrity. Registered staff #604 confirmed at the time of this inspection that they were unable to provide documentation that these areas of skin breakdown were assessed weekly by a member of the registered nursing staff.

C) Clinical documentation confirmed resident #007 was identified on identified dates in June, September and December 2016 as having two areas of altered skin integrity. Registered staff #604 confirmed that at the time of this inspection they were unable to provide documentation to indicate that these areas of skin breakdown were assessed 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”.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that different aspects of care were consistent with and complemented each other.

On an identified date in January 2017, Inspector #583 observed resident #205 transfer them self independently without assistance from the hallway into the washroom. A review of the falls prevention and management care plan completed by the Kinesiologist identified resident #205 required one or two people for transfers for safety and a lift for toileting. A review of the performance of personal care, care plan completed by nursing identified resident #205 required one person for transfers and no lift for toileting.

In an interview with the Resident Assessment Instrument/Quality Improvement (RAI/QI) lead on an identified date in January 2017, it was confirmed that the different aspects of resident #205's transferring and toileting care were not integrated and consistent and did not complement each other. [s. 6. (4) (b)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) A review of a critical incident investigation submitted by the home identified resident #206 was left on the toilet for approximately 15 minutes while Personal Support Worker (PSW) went across the hall to care for another resident on an identified date in

September 2016. In an interview with resident #206 in January 2017, they shared that they are assisted to the toilet by two staff members then they are left unsupervised for a period to use the toilet. A review of the bladder and bowel elimination care plan identified the resident was not to be left alone due to high risk for falls.

In an interview with the RAI/QI lead on January 25, 2017, it was confirmed that the intervention to never leave the resident alone on the toilet was currently in place and was in place on the identified date in September 2016. In an interview with the DNC on January 25, 2017, it was confirmed that the care set out in resident #206’s bladder and bowel elimination care plan was not provided as specified in the plan.

PLEASE NOTE: This non-compliance was identified during a critical incident system inspection, log #027398-16, conducted concurrently during this Resident Quality Inspection. (583)

B) An investigation was completed by the home, after resident #207 alleged they received rough care on an identified date in 2016. During the home's investigation, staff #606 and #607 shared that resident #207 expressed they had pain and discomfort during care on the date of the alleged rough care. It was confirmed by the home during the investigation that resident #207's specialized care intervention related to dressing was not provided as directed in the care plan. This intervention was previously put in place after resident #207 expressed their care was too rough.

In an interview with the DNC on January 25, 2017, it was confirmed that resident #207's care was not provided as directed in their care plan on the identified date in 2016.

PLEASE NOTE: This non-compliance was identified during a critical incident system inspection, log #022905-16, conducted concurrently during this Resident Quality Inspection. (583)

C) On an identified date in January 2017, resident #205 left the room in their wheelchair and transferred independently from the hallway to the washroom and closed the door without assistance. Inspector #583 asked staff #609 and #610 if resident #205 required assistance with transfers and toileting and they shared the resident could complete the task independently. A review of the performance of personal care, care plan identified the resident needed assistance from one staff with transfers and noted the resident was at high risk of falls due to unsteady gait.

In an interview with RAI/QI lead on January 26, 2017, it was confirmed that care set out related to transferring and toileting was not provided to resident #205 as specified in the plan.

PLEASE NOTE: This non-compliance was identified during a critical incident system inspection, log #025407-16, conducted concurrently during this Resident Quality Inspection. (583)

D) Resident #409 demonstrated responsive behaviours and was admitted to the home in 2015 with known responsive behaviours. The home implemented an intervention to minimize the risk for the resident and other residents.

On an identified date in 2016, resident #409 was sitting in a common area and demonstrated a responsive behaviour towards another resident. A specialized intervention to manage resident #409's responsive behaviours that was in place at the time of the incident was not implemented.

It was confirmed during an interview with the Administrator on January 27, 2017, that the care set out in the resident's plan of care had not been provided to the resident, as specified in the plan.

PLEASE NOTE: This non-compliance was identified during a critical incident system inspection, log #034592-16, conducted concurrently during this Resident Quality Inspection. (510a) [s. 6. (7)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that different aspects of care are consistent with and complemented each other and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

1. In accordance with O. Reg. 30 (1)1 the licensee is required to ensure there are policies and procedures for the organized programs identified in section 48 of the Regulations and in accordance with O. Reg. 48(1)1 the licensee is required to develop and implement a falls prevention and management program.

A) i) Resident #204 had a fall on an identified date in November 2016 and sustained injuries. A note to notify the physician was left in the physician's book.

Progress notes documented on two identified dates in November 2016, identified resident #204 had ongoing injury and pain from an identified area. In a progress note completed on an identified date in November 2016, it was documented that the resident was assessed by the physician and a diagnostic test was ordered. In an interview with the DNC on January 20, 2017, it was confirmed the physician was not notified by phone of resident #204's condition and that a diagnostic test was ordered 48 hours after it was identified the resident had an injury.

The results of the diagnostic test were faxed to the home on an identified date in November 2016, which identified resident #204 had an injury. In an interview with the

DNC on January 20, 2017, it was confirmed the physician and the SDM were not notified of the results of the diagnostic test for approximately 38 hours.

A review of the Falls Prevention and Management Policy, approved February 2013, identified staff were to notify the physician when a resident has a fall "by phone if required or noted in the MD book". In an interview with the DNC it was confirmed that staff did not comply with the falls policy. It was shared, it was the home's expectation that the physician would be called when a resident falls and there is an injury and when test results are received that may require an intervention.

ii) Resident #204 had a fall on an identified date in November 2016, and sustained an injury. A review of the post falls assessment and the resident's care plan identified no new interventions or strategies were put in place. A review of the resident's plan of care identified they used an assistive device for ambulation. Two days later resident #204 lost their balance and had a second fall while ambulating without an assistive device which they were unable to use related to their injury.

A review of the Falls Prevention and Management Policy, approved February 2013, identified the purpose of the policy was to implement strategies and interventions to reduce the risk of falls. In an interview with the DNC on January 20, 2017, it was confirmed that no interventions or strategies were put in place after resident #204 first fall to identify how the resident would safely ambulate with their identified injury. It was confirmed the falls policy was not complied with.

B) On an identified date in April 2016, resident #201 returned from hospital with injuries and a change in condition. A progress note documented on an identified date in April 2016, showed the resident had two unwitnessed falls from bed. The plan of care showed no interventions related to falls from bed were put in place till after the falls.

A review of the Falls Prevention and Management Policy, approved February 2013, identified each resident would be assessed when there was a change in condition by the registered team member, for potential risk for falls in order to take a preventative approach. It identified risks, goals, and interventions would be documented in the plan of care.

In an interview with the DNC on January 20, 2017, it was confirmed that the home's falls policy was not complied with as resident #201's falls risk was not reassessed when they returned from hospital with a change in condition.

C) On an identified date in September 2016, resident #202 returned from hospital with injuries and change in condition. Later that night resident #202 was found on the floor with injuries. As per the post fall assessment no interventions were in place at the time of the fall.

A review of the Falls Prevention and Management Policy, approved February 2013, identified each resident would be assessed when there was a change in condition by the registered team member, for potential risk for falls in order to take a preventative approach. It identified risks, goals, and interventions would be documented in the plan of care.

In an interview with the DNC on January 20, 2017 it was confirmed that the home's falls policy was not complied with as resident #202's falls risk was not reassessed when they returned from hospital with a change in condition. (583)

2. In accordance with O. Reg. 30 (1)1 the licensee is required to ensure there are policies and procedures for the organized programs identified in section 48 of the Regulations and in accordance with O. Reg. 48(1) 2 the licensee is required to develop and implement a skin and wound care program.

Staff in the home did not comply with directions contained in the Wound/Skin Care Program identified as Tab 04-78, located in the Nursing Manual with a revised date of August 2016.

This policy provided the following direction to staff:
-ensure that the Skin Assessment is completed accurately and in a timely manner
-registered team members will initiate the Wound Protocol Checklist within 24 hours of a wound being reported.
-registered team members will complete the Wound Assessment Tool of the areas reported which will continue to be completed on a weekly basis by registered team members
-residents with wounds should have an assessment by the Registered Dietitian

A) The DNC confirmed that the policy was not complied with for resident #003. It confirmed that altered skin integrity identified in MDS documentation on identified dates in May and September 2016 as well as progress note documentation on dates in January 2017. The documentation did not include an initial wound assessment or weekly wound

assessments as indicated in the policy.

B) Registered staff #604 confirmed that altered skin integrity identified for resident #006 and resident #007 had not been assessed when they were identified, weekly skin assessments had not been completed, and the Registered Dietitian had not assessed these residents when it was identified that these residents experienced changes in their skin integrity. Registered staff #604 also confirmed that the Wound Protocol Checklist identified in the policy is not being completed as directed in the policy.

3. In accordance with O.Reg 53(1) 1, 2, 3 and 4 the licensee is required to ensure that written protocols and strategies are developed to meet the needs of residents with responsive behaviours.

Staff did not comply with the protocols and strategies identified in the Licensee's policy "Personal Expression Program using The Layered Natured Framework and P.I.E.C.E.S. Approach" identified as Tab 04-84 with a reviewed date of December 2015.

The policy directed that "once the risk has been identified, the PE-Resource/Neighborhood Teams will observe, understand and support the Resident and their Power of Attorney (POA) to identify possible triggers, review the resident's current medications, continue to assess and document events contributing to the expression by utilizing". The Layered Natured Discussion Notes and document in the resident's electronic progress notes the details of the above and the current plan of action.

A) i) Staff did not comply with this policy when resident #005 demonstrated responsive behaviours towards co-residents when it was confirmed by registered staff #604 that there was no documentation to indicate that staff had attempted to identify triggers for the above noted behaviours. Discussion notes had not been completed for resident #005 when the resident continued to demonstrate responsive behaviours and there was no evidence in the electronic progress notes that discussion had occurred between members of the health care team since an identified date in May 2016.

The policy directed that "once an understanding of the resident's personal expressions had been identified and understood, the team will initiate a Neighborhood huddle to discuss support strategies and staff were to continue to documents in the resident's electronic progress notes the support given to team members to ensure the resident's support strategies are effective."

ii) Staff did not comply with this direction when resident #005 continued to demonstrate responsive behaviours towards co-residents when registered staff #604 confirmed that there was no documented evidence that Neighborhood huddles were held and there was no ongoing documentation in the resident's electronic record to indicate staff had reassessed the effectiveness of behaviour management strategies. (129) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessment, reassessment and interventions and that the resident's responses to the

interventions were documented.

A) Resident #005's clinical record indicated that over a 12 month period the resident was involved in 14 episodes of responsive behaviours.

(a) At the time of this inspection registered staff #604 confirmed that they were unable to provide any documented evidence that an attempt had been made to determine possible triggers for resident #005's responsive behaviour towards co-residents. Although the Licensee's policy indicated that staff were to observe, understand and support the resident and their Substitute Decision Makers (SDM) to identify possible triggers when a resident demonstrated responsive behaviors. Staff #604 confirmed they were unaware of any process or organized strategy for the collection of behavioural data in order to determine if there were triggers for responsive behaviours being demonstrated.

(b) At the time of this inspection and following a review of the directions for care related to resident #005's responsive behaviours with co-residents, staff #604 confirmed that strategies had not been developed or implemented to prevent or manage interactions between resident #005 and co-residents.

(c) At the time of this inspection registered staff #604 confirmed they were unable to provide any documented evidence that resident #005 was reassessed in relation to the demonstration of responsive behaviours.

The clinical record confirmed that all consultations completed in 2016, resulted in changes in the resident's medication regime. At the time of this inspection registered staff #604 was unable to provide any evidence that resident #005 was reassessed to determine the effectiveness these changes had on the management of responsive behaviours.

Registered staff #604 confirmed that when a resident demonstrated responsive behaviors the resident was assessed and reassessed by the Physical/Intellectual/Emotional/Capabilities/Environmental/Social (P.I.E.C.E.S) team in the home. Registered staff #604 confirmed that the last P.I.E.C.E.S. documentation in resident #005's clinical record was on an identified date in May 2016, was a review of a specific behavioural episode and there had been no reassessment of the effectiveness of the management of resident #005's responsive behaviours since that date.

PLEASE NOTE: This non-compliance was identified during a critical incident system

inspection, log 001100-17, conducted concurrently during this Resident Quality Inspection. (129)

B) A critical incident report submitted on an identified date in 2015, reported that resident #402 and #401 had a resident to resident altercation that resulted in resident #402 sustaining an injury. The critical incident report identified that resident #401 had been involved in a prior resident to resident altercations.

On an identified date in 2015, resident #401 and resident #406 had an altercation. On an identified date in 2015, resident #401, demonstrated a responsive behaviour towards resident #407.

At the time of the inspection, the clinical records related to each of these three incidents of responsive behaviors, were reviewed, and revealed the absence of evidence that assessment, reassessment and intervention identification, were undertaken. In addition, there was no evidence of documentation of responses to interventions. The DNC confirmed the above.

PLEASE NOTE: This non-compliance was identified during a critical incident system inspection, log #033131-15, conducted concurrently during this Resident Quality Inspection. (510a) [s. 53. (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 for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessment, reassessment and interventions and that the resident’s responses to the interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented, to assist residents who were harmed or at risk of harm as a result of a resident's behaviours.

A critical incident report submitted on an identified November 2015, reported that resident #402 and #401 had a resident to resident altercation that resulted in resident #402 sustaining an injury. The critical incident report identified that resident #401 had been involved in a prior resident to resident altercations.

On an identified date in June 2015, resident #401 and resident #406 had an altercation. On an identified date in July 2015, resident #401, demonstrated a responsive behaviour towards resident #407.

Clinical record review revealed resident #401 had been prescribed an intervention by their physician. Between an identified time period between June and November 2015, the resident refused this intervention. During this period of time, despite three episodes of responsive behaviors, no action was taken to minimize the risk of potentially harmful interactions with other residents. The DNC confirmed the above and that procedures and interventions were not developed and implemented to assist the resident, and minimize the risk of altercations between and among residents. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure procedures and interventions are developed and implemented, to assist residents who are harmed or at risk of harm as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in applicable policy". The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care."

Nursing staff (PSWs) on evening shift were observed completing laundry duties (delivering personal laundry to resident rooms). In an interview on January 24, 2017, with evening PSWs on the Johnston and Cumberland unit it was verified that a PSW on each unit spends approximately 60 minutes delivering personal laundry to residents' rooms during the shift. The Administrator confirmed the PSW staff were paid from NPC funds. [s. 101. (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 licensee complies with the conditions in which the licensee is subject to comply with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that either a physician or a registered nurse in the expended class conducted a physical examination annually.

Registered staff #604 and resident #005's clinical record confirmed that the last annual physical examination was completed on an identified date in September 2015. Although there was an annual physical examination form in the physician's book with a notation that the examination was due in September, an annual physical examination for resident #005 was not completed in 2016. [s. 82. (1) (a)]

Issued on this 28th day of February, 2017

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

Original report signed by the inspector.

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY HAYES (583), IRENE SCHMIDT (510a), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2017_561583_0002
Log No. / Registre no:	034767-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 6, Feb 27, 2017
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF SANDALWOOD PARK 425 Great Lakes Drive, BRAMPTON, ON, L6R-2W8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Zoie Mohammed

To Schlegel Villages Inc, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee is to immediately take the Alenti Lift and Hygiene chairs out of service.

Grounds / Motifs :

1. The licensee failed to ensure that staff use all equipment and devices in the home in accordance with manufacturers' instructions.

During an observation of the spa room on Cumberland, Elliott, and Johnston units it was observed that the Alenti Lift and Hygiene chairs had no safety belts. In an interview with staff #600 and #601 it was shared that they were not aware belts were required when using the Alenti Lift and Hygiene Chair. In an interview with registered staff #603 it was shared that they did not know that a belt was required when using the Alenti Lift and Hygiene Chair. In interview with the Director of Care (DOC) it was confirmed that there were no safety belts or manufacturer's instructions available in the home for the Alenti Lift chairs. A review of the bath schedule on Cumberland, Elliott, and Johnston units identified there were residents whose preference was to receive a bath and baths were schedule for January 6 to January 9, 2017.

The Health Canada alert posted on May 7, 2013, for the Alenti Lift and Hygiene Chair stated "WARNING - The following precautions must be observed at all times when operating the Alenti. Failure to observe these precautions and failure to strictly follow the Instructions for Use can cause serious patient injury. Use of the safety belt at all times".

In an interview with the DOC it was confirmed that no safety belts were available and staff did not know the safety requirements for the use of the Alenti Lift and Hygiene Chair. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 06, 2017

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_449619_0010, CO #001;

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 :

This Order was based upon three factors: severity, scope and history of non-compliance in keeping with section 299(1) of Ont. Regulation 79/10. The severity was identified as 2 (minimal harm or potential for harm/risk), the scope was identified as 3 (widespread) and the compliance history was identified as 4 (ongoing non-compliance with a VPC or CO).

The licensee shall:

1. Immediately implement a monitoring mechanism (to occur every shift until all training has been provided) for all residents who use bed rails to ensure that the mattresses are maintained within the mattress keepers and do not have the ability to move from side to side on the bed deck.

2. Train all registered staff in the completion of an assessment for every resident whose plan of care includes the use of bed rails. This training is to be completed no later than April 30, 2017 and include the following:
i) an assessment that considers all factors identified in the guidance document "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 2013) and be completed using a multidisciplinary approach.
ii) the training is to include specific directions for staff completing the assessment related to documentation of an analysis of the above noted factors as well as care decisions made to minimize the risk of bed entrapment.

3. Immediately upon completion of the above noted training all residents whose plan of care includes the use of bed rails are to be assessed.

4. Train all staff who interact with resident's bed system to ensure that these staff are familiar with all bed system components, how the bed system components are to function and all factors or situations that pose risks to residents related to the bed system components.

5. Develop and implement an ongoing system to monitor staff performance in completing resident assessments according to the training provided as well as staff's completion of ongoing monitoring and reporting of any situations that pose a risk for bed entrapment.

Grounds / Motifs :

1. 1. The licensee failed to ensure that where bed rails were used, the residents

were assessed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

1. On January 19, 2017, the DNC confirmed that the Licensee had not developed a comprehensive bed safety assessment tool using 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 2013) recommended as the prevailing practice for individual resident assessments of bed rails by Health Canada. Following the issuing of a compliance order related to the use of bed rails, served on the Licensee on May 16, 2016, residents were assessed using the "Bed Rail Assessment/Algorithm" that the DOC confirmed was the only tool available at the time the assessments were completed. The "Bed Rail Assessment/Algorithm" was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails. Nine of nine residents reviewed were not assessed for the safe use of bed rails in accordance with the guidance document.

2. Documentation provided by the home at the time of this inspection indicated that the last "Bed Entrapment" audit was completed by the Director of Environmental Services (DES) on January 5, 2017 and at that time all bed systems were identified as having passed all entrapment zone testing. The DNC and the DES confirmed that they were aware of issues related to mattress compatibility with some of the bed frames used in the home. The "Bed Entrapment" audit provided by the home indicated that for 28 of the 119 beds audited notations were entered on the audit that indicated "long mattress-Need 76" which was confirmed to mean that the mattresses currently on those beds were not compatible with the bed frames they were placed on. The DES confirmed that staff had been instructed to pull the fitted bottom sheet over the mattress keepers at the bottom of the bed as a way to keep the mattress within the mattress keepers and prevent potential risks for entrapment. Although there was a plan in place to purchase new mattresses, actions had not been taken to monitor those bed systems that had been identified as having incompatible mattresses and during this inspection six of nine bed systems reviewed were found to not have the mattresses contained within the mattresses keepers allowing the mattress to slide easily from side to side on the bed deck causing a potential entrapment risk between the mattress edge and the bed rails that were

noted to be on those beds.

3. The following observations and the review of clinical records confirmed that residents were not assessed in accordance with expectations contained in the guidance document and actions were not taken to minimize the risk of bed entrapment between mattress edges and bed rails:

A) Resident #300 was noted to be in bed lying on a specified mattress and there were two specified types of bed rails attached to the bed on an identified date in January 2017. The resident's plan of care plan indicated that the resident was to have two bed rails up when in bed and the resident was able to lower the bed rails themselves. The home provided the bed rail assessment that was completed on an identified date in May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

B) Resident #301 was noted to be in bed lying on a specified mattress and there were two specified types of bed rails, without additional specified bed safety interventions, in the up position on an identified date in January 2017. The resident's plan of care indicated that the bed rails were used for Activities of Daily Living (ADL) support and the resident would hold onto the bed rails during positioning. The home provided the bed rail assessment that was completed on an identified date in May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails. Observations made on an identified date in January 2017 and confirmed by the Administrator, DNC and the DES confirmed that the resident was at risk related to bed entrapment when the specified type of mattress, which posed a risk of entrapment between the bed rail and the mattress/ bed deck. At the time this observation was made the DES confirmed that the specified mattress and mattress equipment was not functioning properly.

C) Resident #302 was noted to be in bed lying on a specified mattress without additional specified bed safety interventions and there were two specified bed rails, in the up position on a specified date in January 2017. The resident's plan of care indicated that the bed rails were for ADL support and the resident was able to hold onto the side rails while being repositioned. The home provided the bed rail assessment that was completed on a specified date in May 2016. This assessment was not based on the guidance document and did not consider all

the factors to be considered when assessing a resident related to the safe use of bed rails.

D) Resident #303's bed system was observed on a specified date in January 2017, when it was noted that the bed was equipped with two specified bed rails and the bed frame was equipped with hard plastic mattress keepers. At the time of the observation it was noted that the mattress was not contained within the mattress keepers and moved easily from side to side on the bed deck which created a potential risk of entrapment for this resident between the mattress edge and the bed rails. The resident's plan of care indicated that the resident was independent with bed mobility, two specified bed rails were used for independence with repositioning and the resident was at moderate risk for bed entrapment. The plan of care did not contain any directions to staff related to the actions to take to minimize the risk of entrapment that had been identified. The home provided the bed rail assessment that was completed on an identified date in December 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

E) Resident #304's bed system was observed on a specified date January 2017, when it was noted that the bed was equipped with two specified bed rails, one bed rails was in the up position and the bed frame was equipped with hard plastic mattress keepers. At the time of this observation the bottom of the mattress was not maintained within the mattress keepers and moved easily from side to side on the bed deck which created a potential risk of entrapment for this resident between the mattress edge and the bed rails. This was confirmed on an identified date January 2017, by the Administrator, DNC and DES during observations made on this date. The resident's plan of care indicated that two specified bed rails were used to assist with ADLs related to repositioning and transfers in and out of bed. The home provided the bed rail assessment that was completed on an identified date May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

F) Resident #305's bed system was observed on an identified date in January 2017 and it was noted that the resident was in bed, the bed was equipped with hard plastic mattress keepers and there were two specified bed rails in the up position on both sides of the bed. At the time of this observation the mattress was not contained within the mattress keepers which created a potential

entrapment risk for this resident between the mattress edge and the bed rails. This was confirmed on an identified date in January 2017, by the Administrator, DNC and DES during observations made on this date. The resident's plan of care indicated that the resident was able to hold onto the bed rails, needed total assistance of two staff for repositioning and the bed rails were used to assist with ADLs. The home provided the bed rail assessment that was completed on an identified date in May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

G) Resident # 306's bed system was observed on an identified date in January 2017 and it was noted that the bed was equipped with hard plastic mattress keepers and two specified bed rails were noted to be attached to the bed frame. At the time of this observation it was noted that the mattress was not maintained within the mattress keeps and the mattress moved easily from side to side on the bed deck creating a potential entrapment risk for this resident between the mattress edge and the bed rail. This was confirmed on January 20, 2017 by the Administrator, DNC and DES during observations made on this date. The resident's plan of care indicated that the resident would hold onto the bed rails and independently transfer self from side to side. The home provided the bed rail assessment that was completed on an identified date in May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails.

H) Resident #307's bed system was observed on an identified date January 2017 and it was noted that the bed was equipped hard plastic mattress keepers and two specified bed rails. At the time of this observation it was noted that the mattress was not maintained within the mattress keepers and the mattress moved easily from side to side on the bed deck creating a potential entrapment risk for this resident between the mattress edge and the bed rail. This was confirmed on an identified date in January 2017, by the Administrator, DNC and DES during observations made on this date. The resident's plan of care indicated the bed rails where to assist with ADLs and the resident would hold onto the bed rails during repositioning. The home provided three bed rail assessment completed on an identified date in May 2016 and one bed rail assessment completed on an identified date in November 2016. These assessments were not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of

bed rails.

l) Resident #308's bed system was observed on an identified date January 2017 and it was noted that the bed was equipped with hard plastic mattress keepers and two specified bed rails on both sides of the bed. At the time of this observation it was noted that the mattress was not maintained within the mattress keepers and the mattress moved easily from side to side on the deck creating a potential entrapment risk for this resident between the mattress edge and the bed rails. This was confirmed on an identified date in January 2017, by the Administrator, DNC and DES during observations made on this date. The resident's plan of care indicated the resident was able to independently reposition themselves from side to side using the bed rails. The home provided the bed rail assessment that was completed on an identified date in May 2016. This assessment was not based on the guidance document and did not consider all the factors to be considered when assessing a resident related to the safe use of bed rails. [s. 15. (1)] (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2017

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 :

This order was based upon three factors: severity, scope and history of non-compliance in keeping with section 299(1) of Ont. Regulation 79/10. The severity was 2 (minimal harm or potential for actual harm/risk), the scope was 3 (widespread) and the compliance history was 3 (one or more related non-compliance).

The licensee shall:

1. Complete and document assessments/reassessments for all residents who demonstrate altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds.

2. Complete referrals to the Registered Dietitian for all residents who demonstrate altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds.

3. The Registered Dietitian is to complete and document assessments for all residents who have altered skin integrity.

4. Plans of care are to be developed and implemented to ensure that all staff providing care to residents are aware of skin integrity issues and the plans to manage skin care concerns.

5. Complete at a minimum, weekly reassessments using a clinically appropriate assessment instrumen for all residents who demonstrate altered skin integrity that includes, an evaluation of the effectiveness of the treatment being provided.

6. Develop and implement an ongoing monitoring system to ensure that when a resident demonstrates altered skin integrity the above noted activities are completed and that staff comply with the Licensee's policy.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents exhibiting altered skin integrity, including, 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 is specifically designed for skin and wound.

A) Resident # 003 was identified as having two alterations in skin that were not assessed by a member of the registered nursing staff. The DNC confirmed and

information documented on Minimum Data Set (MDS) completed on an identified dates in May 2016, September 2016 and November 2016 which identified that resident #003 had alterations in their skin integrity on specified areas. The DNC and the clinical record confirmed at the time of this inspection that the home was unable to locate documentation in the resident's clinical record to verify that these changes in the resident's skin integrity were assessed using a clinically appropriate assessment instrument by a member of the registered nursing staff when they were identified.

B) Resident #006 was identified as having two areas of altered skin that were not assessed by a member of the registered nursing staff. Registered staff #604 confirmed and information documented on the MDS completed on an identified date in October 2016, identified that the resident had two areas of altered skin on an identified area as well as a progress note written on an identified date in October 2016, identified that the resident had a third area of altered skin. Registered staff #604 confirmed that at the time of this inspection they were unable to locate any documentation in the resident's clinical record to verify that these changes in the resident's skin integrity were assessed using a clinically appropriate assessment tool by a member of the registered nursing staff when they were identified.

C) Resident #007 was identified as having two areas of altered skin that were not assessed by a member of the registered staff. Registered staff #604 and clinical documentation confirmed and information documented on the MDS completed in June 2016, September 2016 and December 2016, identified the resident had two areas of altered skin integrity on an identified area. Registered staff #604 confirmed that at the time of this inspection they were unable to locate any documentation in the resident's clinical record to verify that these changes in the resident's skin integrity were assessed using a clinically appropriate assessment instrument by a member of the registered nursing staff when they were first identified. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that residents exhibiting altered skin integrity, including, pressure ulcers, skin tears or wounds is assessment by a Registered Dietitian who is a member of the staff of the home and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A) Resident #006 was identified as having two areas of altered skin integrity, this resident was not assessed by the Registered Dietitian (RD). Registered

staff #604 confirmed that at the time of this inspection they were unable to locate any documentation to indicate that a RD had assessed the resident related to changes in the resident's skin integrity.

B) Resident #007 was identified as having two areas of altered skin integrity and this resident was not assessed by a RD. Information documented in the clinical record on identified dates in June, September and December 2016, identified the resident had two areas of altered skin integrity. Staff #604 confirmed that at the time of this inspection they were unable to locate any documentation to indicate that a RD had assessed the resident related to the above noted changes in the resident's skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that residents exhibiting altered skin integrity, including, pressure ulcers, skin tears or wounds were reassessed using a using a clinically appropriate assessment instrument at least weekly by a member of the registered nursing staff.

A) Clinical documentation confirmed resident #003 was identified in May 2016, as having an area of altered skin integrity. In September 2016 a second area of altered skin integrity was identified and in November 2016 a third area of altered skin integrity was identified. The DNC confirmed at the time of this inspection they were unable to provide documentation that these areas of skin breakdown were assessed weekly by a member of the registered nursing staff.

B) Clinical documentation for resident #006 on identified dates in October 2016 confirmed the resident had three areas of altered skin integrity. Registered staff #604 confirmed at the time of this inspection that they were unable to provide documentation that these areas of skin breakdown were assessed weekly by a member of the registered nursing staff.

C) Clinical documentation confirmed resident #007 was identified on identified dates in June, September and December 2016 as having two areas of altered skin integrity. Registered staff #604 confirmed that at the time of this inspection they were unable to provide documentation to indicate that these areas of skin breakdown were assessed weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)] (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee shall ensure that all staff use Alenti Lift and Hygiene Chair and safety belt in accordance with manufacturer's instructions including:
1) Provide education to all direct staff on safe transferring and positioning techniques for all residents related to using the Alenti Lift and Hygiene Chair and application of the safety belt.
2) Develop an auditing process to ensure that all staff are following the manufacturer's instructions for the Alenti Lift and Hygiene Chair.
3) Develop an auditing process to ensure that the Alenti Lift and Hygiene Chair is in good working order and that the safety belt is present in all spa rooms where the lift is being used.

Grounds / Motifs :

1. The licensee failed to ensure that staff use all equipment and devices in the home in accordance with manufacturers' instructions.

During an observation of the spa room on Cumberland unit, Elliott unit, and Johnston unit it was observed that the Alenti Lift and Hygiene Chair had no safety belt. In an interview with staff #600 and #601 it was shared that they were not aware belts were required when using the Alenti Lift and Hygiene Chair. In an interview with registered staff #603 it was shared that they did not know that a belt was required when using the Alenti Lift and Hygiene Chair. In interview with the Director of Nursing Care (DNC) it was confirmed that there were no safety belts or manufacture's instructions available in the home for the Alenti Lift chairs. A review of the bath schedule on Cumberland unit, Elliott unit, and Johnston unit identified there were residents whose preference was to receive a bath.

The "Alenti Instructions for Use, Arjohuntleigh Gentinge Group" dated May 5, 2016, identified the safety belt was to be used at all times. A warning in the manufacturer instructions stated, "To avoid falling, make sure that the patient is positioned correctly and that the safety belt is being used, properly fastened and tightened".

In an interview with the DNC it was confirmed that no safety belts were available and staff did not know the safety requirements for the use of the Alenti Lift and Hygiene Chair. On January 6, 2017, the DNC removed the Alenti Lift and Hygiene Chairs from the spa rooms and put them out of service. The DNC shared the chairs would be pulled from use until safety belts were ordered and received and staff received education on the Alenti Lift and Hygiene Chair and application of the safety belt. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 6th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Hayes

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