Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
Inspection de sions 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
Apr 14, 2016	2016_210169_0003	004528-16	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 HUMBER HEIGHTS
2245 Lawrence Avenue West ETOBICOKE ON M9P 3W3

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

YVONNE WALTON (169), BERNADETTE SUSNIK (120), DARIA TRZOS (561), JESSICA PALADINO (586), KATHLEEN MILLAR (527)

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): February 17, 18, 19, 22, 23, 24, 25, 26, 29, March 1, 2, 3, 4, 8, 9, 2016.

The following inspections were completed with the Resident Quality Inspection and are included in this report.

Complaints: 001214-15 related to resident care, 001622-15 related to elevator

breakdown, 001720-15 related to nutritional care, 008797-15 related to resident care and laundry, 016063-15 related to resident dignity, 019386-15 related to improper care, 020027-15 related to continence care, 021250-15 related to improper care, 024952-15 related to outbreak management, 035119-15 related to skin care, 036073-15 related to elevator breakdown and lift equipment, 001446-16 related to improper care.

Critical Incidents: 006439-14 related to falls management, 002914-15 related to a fracture, 007694-15 related to allegation of abuse, 014653-15 related to allegation of abuse, 016441-15 related to an allegation of verbal abuse, 019688-15 related to an allegation of physical abuse, 024735-15 related to an allegation of abuse, 025326-15 related to a fracture, 030315-15 related to resident to resident abuse, 006498-16 related to a fall with a fracture.

During the course of the inspection, the inspector(s) spoke with Environmental Manager (DES), Administrator, housekeeping staff, maintenance staff, Physiotherapist (PT), Neighbourhood co-ordinators, infection control lead, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI)co-ordinators/Quality Improvement (QI) co-ordinators, personal support workers (PSW), Registered Nursing staff, Kinesiologist, Director of Food Services (DFSS), Assistant Director of Food Services (ADFSS), Administrative Assistant.
The inspectors also spoke with Residents and Families.

The inspectors toured the home, including random resident rooms, common spaces, utility rooms, tub/shower rooms, observed residents in bed, reviewed housekeeping, maintenance, laundry and infection prevention and control policies and procedures, bed system entrapment audits, clinical bed rail use forms, written plan of care for various residents, infection control line listings and surveillance forms, exhaust system and elevator service reports. The inspectors also observed care areas, reviewed clinical records, observed meal service, reviewed minutes of meetings and reviewed the homes records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

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

- **20 WN(s)**
- **9 VPC(s)**
- **1 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 failed to ensure that where bed rails were used residents were assessed in accordance with prevailing practices.

According to prevailing practices titled "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), residents are to be evaluated by an interdisciplinary team over a length of time while in bed, by answering a series of questions to determine if the bed rail is a safe device for resident use. The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective, or if they were previously attempted and determined not to be the treatment of choice for the resident.

Other questions to be considered would include the resident’s medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident’s bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or by the resident's Substitute Decision Maker (SDM), about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

On February 19, 2016, the Director of Care provided a copy of their decision tree

(Appendix C) and policy 06-02 tilted "Bed Entrapment and Bedrail Assessment" dated November 6, 2015. The policy directed (no assigned persons) to assess the resident for the use of their bedrails using Appendix C (decision tree) on "move-in and at any time when a change in bed rail use is required". In addition, the policy directed that their PASD/Restraint Alternatives Assessment be completed when the use of a half or full bed rail was to be employed.

The decision tree (Appendix C), when reviewed did not include any direction for the assessor with respect to bed rail safety issues. Neither the decision tree nor the policy included any of the considerations and questions identified in the prevailing practices document related to interventions, alternatives or risks. The decision tree used by the assessors in the home (neighbourhood co-ordinators and registered staff) was designed to guide the assessor in deciding if the bed rails were either a personal assistance services device (PASD) or a restraint. No safety related considerations were included.

Confirmation was provided by two individual Neighbourhood co-ordinators and the Director of Care (DOC) that residents were not clinically assessed for bed rail safety prior to September 2015. After September 2015, residents who were admitted were assessed using the decision tree if bed rails were being considered as a care intervention for residents. A review of the written plan of care for ten random residents who were admitted prior to September 2015 was completed. The review revealed that four of the identified residents had a plan of care that directed staff to apply bed rails when the resident was in bed as a PASD. The written plan of care for those four residents did not identify why the rails were to be applied and two did not have any information about bed rail usage, even though bed rails were observed to be applied on the residents' beds between February 17 and February 25, 2016.

The staff were not aware of the prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" and therefore did not incorporate the methods and practices into their current assessment process. [s. 15. (1) (a)]

2. The licensee failed to ensure steps were taken to prevent entrapment, taking into consideration all potential zones of entrapment.

The Director of Care (DOC) provided written results from a bed system audit completed between May 20 and June 2, 2015 by a former employee. The employee used a specially designed tool to measure the gaps on beds between the rail and the mattress

that the licensee purchased in October 2014. The results revealed that 45 bed systems failed to pass one or more zones of entrapment in and around the bed rails identified as zones 2, 3 or 4. Some of the reasons the beds failed included missing mattress keepers (to prevent the mattress from sliding side to side), short mattresses, loose bed rails, rail type (rounded at the end) or an older mattress without adequate firmness. According to the maintenance person who was tasked with addressing the issues identified, the beds were not re-tested using the measurement tool after changes were made to the bed. In December 2015, the DOC stated that they hired an external company to re-test the beds but no documentation was available for review from that audit to determine if any of the beds failed one or more entrapment zones. Bed system audits were not completed by any employee of the home between June 2, 2015 and the completion of the inspection. Although initial steps were taken to remedy the failed beds, no verification was made to determine if the beds passed after the changes were made. Other options were not considered such as swapping beds around so that residents who needed one or more bed rails received a passed bed from a resident who did not use the rails.

During the inspection, 3 bed systems were identified to be equipped with a therapeutic surface that cannot be measured for entrapment zones 2-4 due to the soft and compressible design of the mattress. According to prevailing practices identified as “Health Canada Guidelines, Adult Hospital Beds, Latching Reliability and Other Hazards), air mattresses cannot be measured unless they are equipped with side wall reinforcements or they will fail zones 2, 3 and 4 which are associated with gaps in, under and around the bed rail. As a result, residents who use one or more bed rails and who occupy a bed system with a therapeutic mattress must be clinically assessed for safety and entrapment risks associated with the use of bed rails and interventions implemented to reduce those risks.

i) Resident #051 was observed sleeping on a mattress without side wall reinforcement and with both of their ¾ bed rails elevated and in use on February 17, 19, and 23, 2016. The top of the mattress was level with the top of the bed rails and presented a risk of the resident rolling over top of them and onto the floor. No rail height extenders, bolsters, gap fillers or other interventions were seen on the bed. A personal support worker, who was assisting the resident on February 23, 2016 reported that the resident was unable to roll on their own or use the bed rails. The written plan of care for the resident identified that they required two bed rails while in bed as a PASD and that the rails were to keep the mattress in place. The plan did not identify how the resident benefited from using the bed rails and whether they could move involuntarily and could therefore be at high risk of entrapment. According to the resident’s records, the resident received a new mattress

and then fell from the bed. At that time, the bed was equipped with 2 rotating assist rails. Staff confirmed that the ¾ rails were added after. No re-assessment of the resident was completed to determine what risks the ¾ rails presented while on the mattress and no steps were taken to prevent possible entrapment.

ii) Resident #065 was observed sleeping on a mattress with no side wall reinforcement and both of their ¾ bed rails elevated and in use on February 17 and 25, 2016. The resident's care giver stated that the resident did not move while in bed and did not use the bed rails for any purpose. The rails were in use to keep other residents from gaining access to the resident. No gap fillers or other interventions were seen on the bed. The written plan of care for the resident did not include any bed rail information. However, separately, in a binder located at the nurse's station used by personal support workers, a sheet of paper listed the names of residents who required bed rails identified the resident as requiring two rails. No reason was given. No assessment of the resident was completed to determine what risks the ¾ rails presented while on the mattress and no steps were taken to prevent possible entrapment.

iii) Resident #064 was observed sleeping on a mattress with no side wall reinforcement and both of their ¾ rails elevated and in use on February 17, 2016 and February 25, 2016. A wide gap of approximately 4 inches was noted on their right side, between the mattress edge and the bed rail. The mattress was also observed on both dates to be unattached to the deck of the bed. Mattress straps hung loosely down to the floor. No gap fillers or other interventions were instituted to decrease the gaps and prevent possible entrapment. According to the resident's written plan of care dated November 14, 2015, 2 ¾ bed rails were required without any reasons. However, an order was noted in the resident's chart that a doctor ordered the 2 rails as a PASD. No steps were taken to determine what was necessary to mitigate any potential entrapment issues while the resident was in bed and while the rails were in use.

iv) Resident #066 was observed lying in bed on mattresses, with a portable rail tucked under their mattress on their right side and a ¾ rail on their left side on February 17, 2016. Resident #066 was not in bed at the time of the visit on February 17, 2016 but had a portable rail tucked under the mattress on the left side. According to resident #066's family member, the rail was on the bed when the resident moved into the home. The registered staff were not aware of the risks associated with the rails when questioned about why they were being used and who installed them. The portable rails easily slid in and out from under the mattress and created potential entrapment zones. The portable rails are typically sold for residential use and are not a safe substitute in long term care

homes as the beds typically come equipped with rails provided by the manufacturer which can be fixed to the frame. Once reported to the DOC, who was unaware of them, they were removed and a permanent rotating assist rail was applied to the frame of both beds. Resident #066's written plan of care dated January 16, 2016 identified that they needed one half rail and one full rail while in bed as a PASD. Resident #066's plan of care dated February 9, 2016 identified that they needed 1 quarter rail as a PASD. Neither plan identified that a portable rail was in use. Adequate steps were not taken by staff to determine when and by whom the portable rails were installed and for what reason and that all staff were made aware of the risks associated in using them.

v) Resident #228 was seen sleeping on a regular foam mattress with both of the ¾ length bed rails in use on February 17, 2016. The written plan of care dated December 1, 2015 identified that 2 small rails were to be used as a PASD. The resident’s bed failed entrapment zones 2 and 3 on June 2, 2015. The assessor identified that they had 2 ½ rails on the bed. They also made a note that they were not accurately able to determine whether zone 4 passed or failed and that the “patient doesn’t get up”. An assumption could only be made that the test was conducted with the resident in bed which is not in accordance with prevailing practices. Whether staff were not accurate in identifying the rail length or whether the rails were replaced, the bed was not re-tested to determine if the rails passed or failed zones 2-4. [s. 15. (1) (b)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure the written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident.

Resident #049 was at a high nutritional risk. The "Indicators of High Nutritional Risk Present" section of the resident's documented plan of care indicated their fluid goal was 1,200 ml/day; however, the "Heat Risk/Dehydration/Fluid Maintenance" section indicated their fluid requirement as per the RD was 1,500ml/day. Clear direction was not provided to the staff regarding the resident's daily fluid needs. This was confirmed by the DOC. [s. 6. (1) (c)]

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

Resident #041 had plan of care indicating the resident was at high risk for falls and had a medical device in place to alert staff of self-transfers from bed. The resident's room was observed on February 26, 2016 and the device was not attached to the bed and could not be found in the room. The Kinesiologist confirmed that the device was currently being used for resident by checking the written plan of care in resident's chart. The Kinesiologist and the Neighbourhood Coordinator #111 checked the resident's room and could not find the device on the mattress and then found the device sitting on top of the resident's TV. The Neigbourhood Coordinator #111 confirmed that the device has not been used for the resident since December 2015. There was no indication that the resident was reassessed and other interventions used to alert the staff of resident self-transferring. The written plan of care indicated that currently the device was still being used for resident. The resident was not reassessed and their plan of care was not reviewed and revised when the resident's care needs changed or were no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #3: 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 has failed to ensure the home's RD referral policy was complied with.

Resident #024 was at a moderate nutritional risk. Review of the resident's health record confirmed that from January to February 2016, the resident had 6.6% weight loss over one month. Interview with the RD, and review of the home's policy "Weights – Body Weight of Resident" (policy tab 07-29, last reviewed January 2015), confirmed a referral should have been made to the RD as there was significant, undesired weight loss of 5% or more in one month, and the RD confirmed this was not done.

Resident #039 plan of care indicated that they were at risk of dehydration. Their fluid needs were identified as 1,100 millilitres (ml) per day. Review of the resident's Nutrition

and Hydration Flow Sheet for February 2016 confirmed that from February 11 – 27, 2016, 17 consecutive days, the resident was significantly below their ideal fluid intake. The home’s policy “Nutrition and Hydration” (tab 07-24, last revised January 2015) directed staff to send a referral to the RD when there was at least one sign or symptom of dehydration and had a fluid intake of less than 1,000 ml/day for three consecutive days. Interview with registered staff #114 confirmed the resident exhibited weakness which may have been due to dehydration. Interview with the RD confirmed the resident was not meeting their calculated fluid needs and confirmed they did not receive a referral for poor fluid intake. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home’s Medication Pass policy was complied with.

The home’s policy “Medication Pass – MAR/TAR Sheets” (index number 04-02-10, last reviewed June 23, 2014) directed the nurse or care provider to initial in the box opposite that medication for the date and time given whenever a medication was administered. Review of resident #045’s progress notes revealed that on July 8, 2015, an RPN documented they gave the resident a medication. Review of the resident’s medical administration record (MAR) for those dates did not include any documentation to confirm the medications were given. This was confirmed by the DOC. [s. 8. (1) (b)]

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

The home's Fall Prevention & Management [LTC] policy, Tab 04-33, revised February 2013, indicated that "a fall is a sudden, uncontrolled unintentional downward displacement of the body to the ground or other object. If a resident is lowered to the floor with the assistance of Team Members, it should be recorded as a ‘fall’. When a fall is discovered (witness or un-witness), follow the procedures below:
-The Registered Team Member will document the fall using the Falls Incident Report Form located in the current computerized software system.
-The resident will be assessed each shift for 24 hours after the fall by the Registered Team Member who is on the neighbourhood. A progress note will be completed x3 shifts.
-A post fall Analysis will be completed by the Registered Team Member 24 hours after the fall occurred.

Resident #043’s progress notes, indicated that the resident had a fall, witnessed by RPN

and PSW. A RPN #113 confirmed that this was a fall and should have been considered as a fall. Review of the health records indicated that the staff did not consider this as a fall and did not complete the required steps identified in the above policy. The DOC confirmed that this incident should have been considered a fall and that the procedure for falls should have been followed.

Resident #042 had a fall and sustained fracture. The health records were reviewed and indicated that the post fall analysis was not completed after the fall. The interview with the RPN #115 confirmed that the Post Fall Analysis should have been completed after the fall as per the home's policy. The DOC confirmed the same. [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 that ensures 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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with. O. Reg. 79/10, s. 8 (1). r. 8., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that, in the case of a system that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

The resident-staff communication and response system (RSCRS) in the home was confirmed to use both sound and a visual signal to alert staff to an activated station (call bell) or a breached door. The stairwell doors in home areas and the main exit doors were tested on February 19, 2016 by holding them open for more than 25 seconds. The alarm sounded at a nurse's station (closest to the door), but not within the home area other than at the nurse's station. The stairwell exit doors located within each home area were confirmed to be connected to the RSCRS however the audible component was isolated only to the nursing station area. The audible component could not be heard by inspector #120 down at the end of any corridor. Due to the time of day, other sounds drowned out the ringing coming from the panel near the nurses' station. It was observed over several days that staff did not stay at the nurse's station and therefore when working in resident rooms or down at the end of the corridors, staff would not know an alarm was activated. The sound system was not properly calibrated so that the level of sound was audible to staff throughout the home areas. [s. 17. (1) (g)]

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 that ensures that the home is equipped with a resident-staff communication and response system that, (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated. 1. A change of 5 per cent of body weight over one month.

A) Resident #024 was at a moderate nutritional risk. Review of the resident's health record confirmed that the resident lost 6.6% weight loss over one month. Interview with the RD on March 3, 2016, confirmed as of date, the resident had not been assessed by the RD for significant weight loss.

B) Resident #032 was at a moderate nutritional risk. Review of the resident's health record confirmed that the resident lost 5 kg (6.8% weight loss over one month). The RD was sent a referral and assessed the resident on, in which they documented through a progress note that this was likely a scale error and to have nursing notify the RD if weight loss was confirmed. Review of the health record and interview with the RD confirmed that the weight loss was verified; however, they did not assess the resident until a month later, because the resident continued to lose further weight (5% significant weight loss over one month). The RD confirmed the resident was not reassessed when the weight loss was verified and that actions were not taken regarding the resident's significant weight loss.

C) Resident #039 was at a high nutritional risk. Review of the resident's health record confirmed that the resident lost 6% weight loss over one month. The RD was sent a referral and assessed the resident, in which they documented through a progress note that this was a potential scale error, that the resident was eating 50-75% at meals, and to have nursing notify the RD if weight loss was confirmed at the following month. Review of the health record and interview with the RD confirmed that the weight loss was verified, as the resident continued to lose further weight; however, they did not assess the resident until three months later. The RD confirmed the resident was not reassessed when the weight loss was verified and that actions were not taken regarding the resident's significant weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 that ensures that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months. 4. Any other weight change that compromises the resident’s health status. O. Reg. 79/10, s. 69, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff had received retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protection in accordance with O. Reg. 221(2).

During the Resident Quality Inspection (RQI) PSW #128, #129 and registered staff #108 were interviewed and were unsure if they had received retraining of abuse and neglect. The home`s training records were reviewed and identified that 196 out of 232 (84%) staff received training in 2015. The Director of Care (DOC) confirmed that the home had not ensured that all staff had received retraining related to the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protection annually. [s. 76. (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 that ensures that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4), to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee did not ensure that there were schedules and procedures in place for preventive maintenance related to the resident-staff communication and response system and interior furnishings and surfaces.

A) Resident-staff communication and response system:

On February 19, 2016, after testing and identifying that the alarm component on several stairwell door access key pads, located in various home areas did not function. The Director of Environmental Services (DES) was requested to provide records to prove that the door access control system was being monitored and maintained. No procedures or preventive audits were available for review. According to both the Administrator and DES, the system which included the key pads (and internal alarm), the magnetic plates, latching and closing hardware, the sound system connected to the stairwell and exit doors and the visual panel located at each nursing station was not regularly tested for adequate function. The maintenance program did not include a preventive component for

the resident-staff communication and response system.

B) Interior Surfaces and Furnishings:

During a tour of the home on February 17, 2016, the interior of the home, such as walls, doors, door hardware, ceilings, flooring, furnishings, carpeting, fixtures (toilets/sinks), lights and windows were observed for function and condition. Various maintenance issues (as noted below) were identified and when procedures and schedules for repair were requested, none were available. The licensee’s policies and procedures for preventive maintenance did not include interior surfaces or furnishings. Preventive tasks would include but not be limited to what interior surfaces to audit, the expected condition, available follow-up actions, schedule of auditing, time frame for follow up or person responsible. According to the DES, interior surfaces and furnishings were not programmed into their computerized preventive maintenance system for preventive auditing. Preventive audits were therefore not completed of resident rooms and ensuite washrooms, tubs and shower rooms, lounges, dining rooms or utility rooms on a regular basis. During the inspection, many rooms were identified to have severe wall damage due to motorized wheelchair use by residents. A wall condition audit was recently completed (date missing from the audit) of resident rooms by the DES and plans were in place to repair them and protect them from further damage. However no wall condition or interior surface procedure was available for review. The following issues were identified at the time of inspection:

*Two 4 to 5 inch cracks or breaks were observed within the shower area (along the coved floor/wall junction). Rips or tears were observed in the flooring material around the floor drains. Various resident rooms had loose floor tiles.
* The walls around the cabinet and counter top with the hand sink located in most of the dining rooms were gouged, eroded or water damaged.
* Cabinet surfaces in various tub rooms were gouged or deeply scratched.
* Bathroom vanities were chipped in in various resident ensuite washrooms.
* Doors were not closing properly (stuck on frame) in a tub and shower room and a soiled utility room and door slammed shut on another tub room (self closing device on door not adjusted properly).
* Toilets were leaking from tank to bowl in several resident ensuite washrooms.
*Light bulbs were burnt out in various shower areas.[s. 90. (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 that ensures that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1), to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home had a medical directive in which the Constipation/Bowel Routine section directed staff to administer 30 millilitres (ml) Milk of Magnesia (MOM) if a resident did not have a bowel movement (BM) after two days, then administer a Dulcolax suppository if no BM after three days, and a fleet enema after lunch on the third day.

A review of the clinical record for resident #045 identified that staff did not consistently follow the medical directive.

i. The resident did not have a BM for seven days. No interventions were given until six days later.

ii. Progress notes indicated the resident did not have a BM for the five days following. No interventions were given until five days later.

Drugs were not administered to resident #045 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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

Resident #051 had a medical need for specific medications which the resident did not receive.

Staff #113 and #132 were interviewed and confirmed the medications for the resident was ordered by the physician. The staff were unable to confirm if the resident received their medications, and identified that it was important that they received the medications due to their medical conditions. The home did not ensure that the medications ordered for resident #051 were administered to the resident in accordance with the directions for use specified by the physician. [s. 131. (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 that ensures that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2), to be implemented voluntarily.

WN #9: 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. (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 did not ensure that all staff participated in the implementation of the infection prevention and control program.

Cleaning and disinfection practices are part of the infection prevention and control program which includes but is not limited to cleaning and disinfecting personal care devices such as wash basins, urine hats, urinals and bed pans in accordance with evidence-based practices.

According to a document titled "Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, 2013", non-critical devices such as bed pans and wash basins are to be cleaned and disinfected with a low level disinfectant after each use (unless the device is not used by any other person whereby cleaning is sufficient). Bed pans and wash basins act as vehicles for the transmission of pathogenic organisms, from one body area to another (in the case when wash basins are used for bed baths) and from staff hands to other surfaces when not adequately handled, cleaned and disinfected when necessary.

According to the home’s policy for cleaning bed pans and basins (“Personal Care Ware” 06-02), the wash basins were required to be disinfected weekly and as needed. There

were also to be collected by the personal support worker (PSW), taken to the soiled utility room and visible debris removed prior to cleaning. They would then need to be washed in the dishwasher if available, followed by disinfection. The devices were to be labeled and kept off the floor. The above noted procedure was not developed in full, taking into consideration some much needed details to prevent cross contamination and to minimize the spread of pathogens. Missing from the procedure included: Where to discard dirty water or bodily fluids before taking them down the hall to the soiled utility room. Where and how to clean the devices prior to using the dishwasher (the dishwasher was not located in the soiled utility room, but in a housekeeper's storage room). How to use the dishwasher (cycle selection, type of detergents). When to clean vs disinfect the articles (daily cleaning routine not included).Where to store the devices once cleaned.

According to the infection control lead and PSWs, a schedule was to be followed whereby a certain number of devices were to be cleaned every week, in conjunction with the residents' bath day. The PSW responsible for cleaning the devices were required to sign and date when the devices were cleaned. The information was kept in binders identified as "Night Shift Cleaning" stored at each nurses' station in each home area.

A) During a tour of resident washrooms on February 17, 2016, a very soiled wash basin was noted. It was still dirty upon return on February 24, 2016. On February 17, 2016 a soiled bed pan was noted on the floor. It remained on the floor and in the same condition on February 24, 2016. The urine hat had urine stains in it and a bed pan was on the floor on Feb. 24th. Two blue wash basins had white stains on them. These are examples of devices not being cleaned after each use and stored appropriately in accordance with evidence-based practices.

B) During a tour of the soiled utility rooms in the home, which were all equipped with a flushable hopper and a stainless steel sink, no detergent or brushes were observed and available for use in the rooms. Disinfectant in a spray bottle was however provided. No cleaning instructions were posted. All 6 housekeeping storage rooms were visited, each equipped with a domestic style dishwasher. The dishwashers were checked on February 24, 2016. One dishwasher had a stainless steel commode pot in it which remained in place when checked again on March 1, 2016. Paper towel was inserted on the top rack for monitoring of use and upon return on February 25, 2016, was gone. Paper towel was re-inserted on February 25, 2016 and removed again when checked on March 1, 2016.

On February 25, 2016 the dishwashers were checked. One had floor cleaning pads in it which remained until checked again on March 1, 2016. Paper towel was inserted into the

machine. On March 2, 2016, paper towel was placed in dishwashers and on March 4, 2016, the paper towel remained in place. Based on the observations, it appeared that PSWs were not using the dishwashers in any home area except one. Evidence was not available to support that PSWs were cleaning and disinfecting the personal care ware at least once per week.

C) The night shift cleaning logs for personal ware was reviewed. The cleaning logs could not be located by Inspector #120 or by staff in one home area. The staff responsible for signing and acknowledging that the devices were cleaned and disinfected did not sign the logs for the majority of the residents listed in the binders. The last recorded dates included November and December 2015. Evidence was not available to support that PSWs were cleaning and disinfecting the personal care ware at least once per week.

The neighbourhood co-ordinator confirmed that no process was in place to verify and ensure that staff were cleaning and disinfecting the personal ware. They also confirmed they did not personally review the cleaning logs or the practices of staff in handling the personal ware. The procedures were not fully developed to incorporate practices identified in the above noted best practices document and PSWs did not appear to have implemented what procedures were available to them. [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 that ensures that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4), to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the emergency plans provided for the loss of one or more essential services. According to section 19(1)(c) of Regulation 79/10 (Amended 399/15) an essential service includes elevators.

The home is designed with one elevator on each tower or wing (east and west) consisting of 3 floors each. According to elevator service records for 2014 and 2015, the west wing elevator was down between mid December 2014 and the end of January 2015. The east wing elevator was not functional for 10 hours on January 12, 2015, at the same time that the west wing elevator was down. According to the Administrator, the non-written contingency plan established if one elevator was not functional included staff using an elevator on the opposite tower which was connected by a service corridor. Residents were apparently escorted by staff through the service corridor to an elevator on the opposite tower on multiple occasions in 2015. No written plans were available for review identifying how the provision of care and services would continue for residents, how visitors would be notified and affected, how residents who could not use the stairs would be escorted in and out of the home when both elevators were non-functional. [s. 230. (4) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the emergency plans provide for the following: 1. Dealing with, i. fires, ii. community disasters, iii. violent outbursts, iv. bomb threats, v. medical emergencies, vi. chemical spills, vii. situations involving a missing resident, and viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4), to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

There was an allegation of abuse against resident #044. The home's zero tolerance for abuse and neglect policy called "Prevention of Abuse in Long-Term Care", number 04-06, and revised July 2015, directed all team members to report any suspicions, incidents, or allegations of abuse immediately, and to follow s. 24 mandatory reporting in the Long Term Care Home's Act, 2007. The home did not notify the Director of the allegation of abuse until 12 days after the incident. The home was unable to find any documentation that the Director was notified immediately of the alleged abuse. The LTC Inspector confirmed with the Centralized Intake Assessment Triage Team (CIATT) that they had no record of such an incident being reported to the Director. The DOC also confirmed that the home had not notified the Director of the alleged abuse until 12 days after the incident occurred. The home's policy to promote zero tolerance of abuse and neglect of residents was not complied with. [s. 20. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that (a) a care conference of the interdisciplinary team providing a resident’s care was held at least annually to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker; (b) the resident, the resident’s substitute decision-maker, if any, and any person that either of them may direct were given an opportunity to participate fully in the conferences; and (c) a record was kept of the date, the participants and the results of the conferences.

During an interview with a resident's family member, they identified that they had not been invited to the annual care conference for resident #025 in a few years. Reviewed the resident's clinical record and reviewed the home's policy called "Care Conferences (Admission & Annual)", number 04-08 and revised October 2013. The policy identified that the Administrative Assistant would book the Care Conference and notify the multidisciplinary team once the date and time were confirmed. The policy also directed staff to record the details discussed at the Care Conference as "Care Conference Progress Note" in the current computerized software system. The Administrative Assistant was interviewed, they identified they were new to the home and was not able to identify if the resident's Substitute Decision Maker (SDM) was invited to the annual care conference. The Administrator was interviewed and identified that the Neighbourhood Coordinator (NC) was responsible for coordinating and scheduling the annual care conference for the resident. The Neighbourhood Coordinator was interviewed and they were unable to locate any schedule or "Care Conference Progress Note" in the clinical record that the resident's family and/or SDM were invited to the annual care conference in 2014 and 2015. The Neighbourhood Coordinator confirmed that the family and/or SDM were invited to the resident's annual care conference in 2014 and 2015. The resident's family and/or SDM were not provided the opportunity to discuss the resident's plan of care, to participate fully in the care conference, and there was no record kept of the date, the participants and the results of the annual care conference. [s. 27. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Resident #051’s documented plan of care indicated that they needed to be turned and repositioned every two hours. The resident’s Repositioning Records, which staff were to complete each time the resident was repositioned, was observed to be incomplete, with several dates left blank. This was confirmed by the DOC.

B) Resident #045’s health care record identified that the resident required total care from staff for routine oral hygiene. Their Personal Care Observation and Monitoring Forms, which staff were to complete in full on a daily basis at each shift, was observed to be incomplete, with several dates left blank. [s. 30. (2)]

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

The progress notes indicated that resident had a fall. In review of the progress notes and the post fall assessment it was found that the initial assessment by the RPN who attended to the fall was not documented. The post fall assessment form was completed by the Nurse in Charge. The interview with the DOC confirmed that the RPN who first attended to the fall should have documented her initial assessment in either the progress note or the post fall assessment form. [s. 30. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter, (ii) height upon admission and annually thereafter.

An audit of the home's weight records revealed that several residents from each of the six home areas did not have their weights taken and documented between November 2015 and February 2016. This was confirmed by the RD. In addition, the home's policy "Weight & Height Monitoring" (tab 07-32, last revised August 2015) stated that weight measurements were to be entered into Village Software (GoldCare); however, record review and interview with the RD confirmed that some residents' weights were documented on paper but were not entered into GoldCare.

The home did not ensure that all current resident's heights were taken annually as evidenced by review of the resident's clinical records. The DOC confirmed annual heights were not being done on all residents in the home. [s. 68. (2) (e)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #051, who required assistance with eating, was assisted using safe positioning techniques.

Resident #051’s plan of care indicated they required total assistance with feeding and was to receive a pureed diet.

During dinner meal service PSW #122 was observed feeding resident #051 in their room while the resident was lying down in bed. Their bed was elevated at less than a 45 degree angle and should have been up at a 90 degree angle. Interview with the RD confirmed residents must be fed sitting up for safety reasons as it puts them at increased risk for choking. [s. 73. (1) 10.]

2. The licensee has failed to ensure residents who require assistance with eating or drinking are not served a meal until someone was available to provide the assistance required by the resident.

During lunch meal service, 3 residents beverages (including water, juice, milk and milkshakes) were placed on the tables in front of the residents prior to assistance being available.
Meal service commenced at 1200 hours and 2 residents drinks sat in front of them until they were assisted at 1245 hours, and one resident until 1311 hours. [s. 73. (2) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the designated lead for housekeeping, laundry and maintenance had knowledge of prevailing practices in the fields of housekeeping, laundry and maintenance or a minimum of two years experience in a managerial or supervisory capacity.

The designated lead for housekeeping, laundry and maintenance was hired given the title of Director of Environmental Services. The lead did not attend nor was enrolled in any courses related to the fields of housekeeping, laundry and maintenance to ensure that they had adequate knowledge of the prevailing practices in those fields. The lead reported that they had a total of 6 months supervisory capacity overseeing students in an unrelated field. [s. 92. (2)]

WN #17: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The home failed to ensure that the resident’s substitute decision-maker (SDM) was notified within 12 hours upon the licensee becoming aware of the alleged abuse of resident #044.

There was an allegation of abuse against resident #044. The resident’s clinical record was reviewed and there was no documentation related to the resident’s SDM being notified of the alleged abuse. The home’s investigative notes were reviewed and there was no documentation that the resident’s SDM was notified of the incident. The DOC confirmed that the resident’s SDM was not notified of the alleged abuse within 12 hours of becoming aware of the incident. [s. 97. (1) (b)]

WN #18: 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):
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).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was 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):

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 a breakdown of a system in the home or a loss of essential services.

According to section 19(1)(c) of Regulation 79/10 (Amended 399/15) an essential service includes elevators. Elevators are also considered a system.

The licensee did not inform the Director (using the Critical Incident System) on more than one occasion that one or more elevators used by residents in the home were out of service for more than 6 hours. The west side elevator was not functional between mid December 2014 until the end of January 2015. Exact dates could not be provided by either the Administrator and were not identified on the elevator service reports. The elevator on the east side was not functional between 7:30 a.m. and 5:30 p.m. on January 12, 2015 and therefore neither elevator was available for resident use on January 12, 2015.

Elevators that were not operational for more than 6 hours affected the well being of residents, especially those who regularly used the elevators independently or needed to leave the building on a daily basis. According to residents affected by the lack of elevator service, getting to and from their floor required waiting for available staff to escort them through a service corridor which linked the west side of the building to the east side of the building to another elevator. Waiting on available staff caused them distress and aggravation and contributed to their loss of independence. When both elevators were not functional, residents who could not use the stairs were isolated to their floor for the duration of the elevator failure. [s. 107. (3) 2.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart, iv. that complied with manufacturer's instructions for the storage of the drugs.

On March 4, 2016 the LTC Inspector found the following medications that were expired in the cabinet where the government stock was being stored:

The DOC and the RN #126 confirmed that these medications should have been disposed of. [s. 129. (1)]

2. The licensee failed to ensure that, (a) drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies.

During an observation of the medication pass, the LTC Inspector found the following personal resident items in the narcotic bins in the medication carts:

- wrist watches,
- eye glasses,
- assorted jewelery,
- a small black change purse,
- coins, and
- ziploc bags,

The registered staff #125, #126, #132 and #133 identified that these items were stored in the narcotic bin for safe keeping. The home failed to ensure that drugs were stored in a medication cart that was exclusively used for drugs. [s. 129. (1) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in falls prevention and management.

The home's training records and the DOC confirmed that 173 out of 194 (89%) direct care providers completed training in the Falls Management and Prevention in 2015. [s. 221. (1) 1.]

Issued on this 14th day of April, 2016

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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	YVONNE WALTON (169), BERNADETTE SUSNIK (120), DARIA TRZOS (561), JESSICA PALADINO (586), KATHLEEN MILLAR (527)
Inspection No. / No de l'inspection :	2016_210169_0003
Log No. / Registre no:	004528-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 14, 2016
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 HUMBER HEIGHTS 2245 Lawrence Avenue West, ETOBICOKE, ON, M9P-3W3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pauline Delloso

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Order: 153(1)(a) 15(1)(b)

The licensee shall complete the following:
1. Immediately implement interventions to reduce or eliminate entrapment zones for those residents, beginning with residents #051, #064 and #065, who have a therapeutic surface on their bed frame and who use one or more bed rails. Document the intervention(s) utilized in the residents' written plan of care.
2. Develop or amend existing clinical bed safety questionnaires and decision making documents to include questions related to bed rail safety as identified in the prevailing practice guidelines identified in the US Food and Drug Administration's (FDA) document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
3. All staff that are, or will be involved in clinically assessing the residents for bed rail use shall use the guidelines identified in the FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
4. Re-assess all residents who use a bed rail by employing the amended bed rail safety questionnaires developed in #2 above.
5. The result of the assessment shall be documented in the residents' written plan of care and the information regarding the resident's bed rail use (which side of bed, size of rail, how many rails and why) shall be clearly identified so that health care staff have clear direction when to employ a bed rail.
6. All staff who provide care to residents shall receive education on the hazards of bed rail use and be aware of their role in reporting bed rail entrapment, injury or near misses to registered staff

Grounds / Motifs :

1. The licensee failed to ensure steps were taken to prevent entrapment, taking into consideration all potential zones of entrapment.

A) The Director of Care (DOC) provided written results from a bed system audit completed between May 20 and June 2, 2015 by a former employee. The employee used a specially designed tool to measure the gaps on beds between the rail and the mattress that the licensee purchased in October 2014. The results revealed that 45 bed systems failed to pass one or more zones of entrapment in and around the bed rails identified as zones 2, 3 or 4. Some of the reasons the beds failed included missing mattress keepers (to prevent the mattress from sliding side to side), short mattresses, loose bed rails, rail type

(rounded at the end) or an older mattress without adequate firmness. According to the maintenance person who was tasked with addressing the issues identified, the beds were not re-tested using the measurement tool after changes were made to the bed. In December 2015, the DOC stated that they hired an external company to re-test the beds but no documentation was available for review from that audit to determine if any of the beds failed one or more entrapment zones. Bed system audits were not completed by any employee of the home between June 2, 2015. Although initial steps were taken to remedy the failed beds, no verification was made to determine if the beds passed after the changes were made. Other options were not considered such as swapping beds around so that residents who needed one or more bed rails received a passed bed from a resident who did not use the rails.

B) During the inspection, 3 bed systems were identified to be equipped with a therapeutic surface that cannot be measured for entrapment zones 2-4 due to the soft and compressible design of the mattress. According to prevailing practices identified as “Health Canada Guidelines, Adult Hospital Beds, Latching Reliability and Other Hazards), air mattresses cannot be measured unless they are equipped with side wall reinforcements or they will fail zones 2, 3 and 4 which are associated with gaps in, under and around the bed rail. As a result, residents who use one or more bed rails and who occupy a bed system with a therapeutic mattress must be clinically assessed for safety and entrapment risks associated with the use of bed rails and interventions implemented to reduce those risks.

i) Resident #051 was observed sleeping on a therapeutic surface without side wall reinforcement and with both of their padded ¾ bed rails elevated and in use on February 17, 19, and 23, 2016. The top of the surface was level with the top of the bed rails and presented a risk for the resident. No rail height extenders, bolsters, gap fillers or other interventions were seen on the bed. The written plan of care for the resident identified that they required two bed rails while in bed as a PASD and that the rails were to keep the mattress in place. The plan did not identify how the resident benefited from using the bed rails. According to the resident's records, the resident received a new surface, then fell from the bed. At that time, the bed was equipped with 2 rotating assist rails. Staff confirmed that the ¾ rails were added after. No re-assessment of the resident was completed to determine what risks the ¾ rails presented while on the surface and no steps were taken to prevent possible entrapment.

ii) Resident #065 was observed sleeping on a therapeutic mattress with no side wall reinforcement and both of their ¾ bed rails elevated and in use on February 17 and 25, 2016. No gap fillers or other interventions were seen on the bed. The written plan of care for the resident did not include any bed rail information. However, separately in a binder located at the nurse's station, used by personal support workers, a sheet of paper listed the names of residents who required bed rails. It also identified the resident as requiring two rails. No reason was given. No assessment of the resident was completed to determine what risks the ¾ rails presented while on the air mattress and no steps were taken to prevent possible entrapment.

iii) Resident #064 was observed sleeping on a therapeutic mattress with no side wall reinforcement and both of their ¾ rails elevated and in use on February 17, 2016 and February 25, 2016. A wide gap of approximately 4 inches was noted on their right side, between the mattress edge and the bed rail. The mattress was also observed on both dates to be unattached to the deck of the bed. No gap fillers or other interventions were instituted to decrease the gaps and prevent possible entrapment. According to the resident's written plan of care dated November 14, 2015, 2 ¾ bed rails were required without any reasons. However, an order was noted in the resident's chart that a doctor ordered the 2 rails as a PASD. No steps were taken to determine what was necessary to mitigate any potential entrapment issues while the resident was in bed and while the rails were in use.

iv) Resident #066 was observed lying in bed on a therapeutic surface with a portable rail tucked under their mattress. According to resident #066 family member, the rail was on the bed when the resident moved into the home in November 2015. The registered staff were not aware of the risks associated with the rails when questioned about why they were being used and who installed them. The portable rails easily slid in and out from under the mattress and created potential entrapment zones. The portable rails are typically sold for residential use and are not a safe substitute in long term care homes as the beds typically come equipped with rails provided by the manufacturer which can be fixed to the frame. Once reported to the DOC, who was unaware of them, they were removed and a permanent rotating assist rail was applied to the frame of both beds. Resident #066's written plan of care dated January 16, 2016 identified that they needed one half rail and one full rail while in bed as a PASD. Resident #066s plan of care dated February 9, 2016 identified that they needed 1 quarter rail as a PASD. Neither plan identified that a portable rail was in use.

Adequate steps were not taken by staff to determine when and by whom the portable rails were installed and for what reason and that all staff were made aware of the risks associated in using them.

v) Resident #228 was seen sleeping on a mattress with both of ¾ length bed rails in use on February 17, 2016. The written plan of care dated December 1, 2015 identified that 2 small rails were to be used as a PASD. The resident's bed failed entrapment zones 2 and 3 on June 2, 2015 and the assessor identified that they had 2 ½ rails on the bed. They also made a note that they were not accurately able to determine whether zone 4 passed or failed. An assumption could only be made that the test was conducted with the resident in bed which is not in accordance with prevailing practices. Whether staff were not accurate in identifying the rail length or whether the rails were replaced, the bed was not re-tested to determine if the rails passed or failed zones 2-4.

The judgment matrix was assessed as follows:
The severity of the non-compliance potential. The scope of the non-compliance is widespread.
A review of the home's compliance history revealed that LTCHA, 2007, c.8, Section 15 has been previously issued in January, August and November 2015.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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 sions 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 sions 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 14th day of April, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : YVONNE WALTON

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