Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 28, 2015	2015_168202_0006	T-1643-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE ONTARIO MISSION OF THE DEAF
2395 BAYVIEW AVENUE NORTH YORK ON M2L 1A2

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

BOB RUMBALL HOME FOR THE DEAF
1 Royal Parkside Drive BARRIE ON L4M 0C4

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

VALERIE JOHNSTON (202), DIANE BROWN (110), VALERIE PIMENTEL (557)

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): April 24, 27, 28, 29, 30, May 01, 04, 05, 06, 07, 08, 11, 12, 13, 2015.

During the course of the inspection the following complaint inspections were completed: T-2127-15, T-2128-15, T-2112-15, T-1168-14 and a follow up inspection, T-2107-15.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), assistant director of care (ADOC), environmental services manager (ESM), registered dietitian (RD), food services manager, food service worker, rai-coordinator, director of support services, program coordinator (PC), registered nursing staff, personal support workers (PSW), families, volunteer and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **20 WN(s)**
- **11 VPC(s)**
- **4 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 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A review of the written care plan for resident #04 identified the following focuses related to transferring and toileting:
1. Resident requires one person assist, two person when necessary for transferring.
2. Requires extensive assistance for toileting.
3. Requires two person assistance for all transfers, and to use a sit to stand mechanical

lift when necessary.
The resident's kardex identified the following:
1. Resident is able to transfer with assistance and can weight bear.
2. Requires two person assistance for all transfers and staff to use a sit to stand mechanical lift whenever necessary.

The residents progress notes identified that he/she uses an assistive device for toileting. PSW #108 confirmed in an interview that the resident will independently toilet him/herself without assistance.
Interviews with PSW #108 and RPN #132 identified that the resident was to be assisted by one person with transfers and no longer required extensive assistance with toileting. The staff confirmed that the written plan of care does not provide clear direction when providing assistance with toileting and transfers. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Resident #37 is at high nutritional risk related to weight loss and intake. Record review and staff interviews identified that resident #37 is frequently food seeking. Resident is known to have sleep patterns affecting food intake.

Interviews with registered staff #119 and #118 revealed that the resident's preference to eat food an an identified time is not always accommodated as food is not available to be served and a nutritional supplement has been requested as an alternative. An interview with the dietary aide #116 revealed that food is available in the servery but confirmed that he/she has not heard from nursing staff that there isn't any preferred food available for resident #37. The RD assessment of an identified date, confirmed that resident #37 is food seeking, has lost weight and that food is available in the servery to be offered to the resident. The care set out in the plan of care had not been based on an assessment of resident #37's food preferences and the availability of preferred foods for resident #37 when requesting. [s. 6. (2)]

3. The written plan of care for resident #36 directs staff to provide the resident with a bath/shower every Wednesday and Saturday and to provide prompted toileting assistance at a scheduled time of 6:00 a.m. Direct care staff interviews indicated that when the resident is approached at 6:00 a.m., he/she will become agitated. Staff indicated that the resident preferred to sleep in and most days the resident will sleep skipping the breakfast meal.

A review of the clinical records for the resident for an identified four month period, revealed that the resident refused care offered at 6:00 a.m., for 20 days in month A, 24 days in month B, 25 days in month C and 23 days in month D.

Staff interviews indicated that one month prior, the management of the home, in order to decrease the work load from the day shift staff, directed night staff to provide a bath to four residents during the night shift. Staff indicated that resident #36 was chosen by management to have a night bath provided at 06:00 a.m., and to continue with prompted toileting at the same time. An interview with the DOC confirmed the above, and that the resident's plan of care had not been based on the resident's preference to sleep in past often past breakfast meal service. [s. 6. (2)]

4. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The inspector observed on an identified date, resident #02 transfer him/herself to toilet independently.

Record review of resident #02's written plan of care identified that the resident required two staff assistance for all transfers as directed by the physiotherapist. Interviews with PSW #129 and RPN #123 confirmed that the resident only required one staff member for all transfers. RPN #123 confirmed that both nursing and the physiotherapist did not collaborate with each other in the assessment of the resident so that their assessments are integrated and complement each other. [s. 6. (4) (a)]

5. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other 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.

LTCHA, 2007, c. 8, s. 6 (4) has been the subject of a previous compliance order for resident #33. Resident #33 was identified in the inspection report #2014_168202_0028 which was issued to the home on January 27, 2015, with a compliance date of April 30, 2015. The home's plan required in the January 27, 2015 compliance order, involving resident #33 was ineffective, as confirmed by the findings below.

The plan of care for resident #33 indicated that the resident's bed is to be in the lowest position while he/she is in bed, and that the bed rails are to be raised as per substitute decision maker (SDM) request. A review of the resident's records revealed no physician order for the use of bed rails.
Direct care staff were interviewed and revealed inconsistent knowledge of the purpose and use of resident #33's bed rails as follows:

PSW #128 indicated that resident #33 has two 1/4 length bed rails raised when the resident is in bed and that they are not considered to be a restraint for the resident. Staff continued to state that the resident is not able to get out of bed on his/her own with or without the use of the bed rails, is at risk of choking, and that the bed rails are used as a "turning aid" for staff when assisting the resident.

PSW #129 indicated that resident #33 is at risk of sliding out of his/her bed. Staff continued to state that the resident is to have his/her bed low to the ground with 1/4 length bed rails raised. Furthermore, the staff indicated that the bed rails are only used to position pillows allowing the resident to sit up in bed to accommodate his/her preference.

RPN #121 indicated that resident #33 diagnosis placed the resident at risk for choking, that the resident preferred to sit up in bed with bed rails raised. Furthermore, the RPN stated that the bed rails would prevent the resident from falling out of bed, however, if the resident was to fall into the rails, he/she would not be able to position him/herself away from the bed rails. When questioned by inspector if the bed rails are a restraint for the resident, the RPN indicated "no" because hourly checks were not part of the resident's plan of care. The RPN revealed that it was unclear what the bed rails were intended for, as there was no physician order for use of the bed rails which would normally have been in place if the bed rails were considered a restraint.

RPN #120 indicated in an interview that resident #33 used two 1/4 length bed rails that are to be raised when he/she is in bed to prevent him/her from falling out of bed. When questioned whether the bed rails were a restraint, the RPN confirmed he/she was unsure. The RPN further stated that because staff were completing hourly checks, it must indicate that the bed rails are a restraint for the resident.

PSW #125 indicated that resident #33 will lean over in bed into the 1/4 length bed rails but was unsure when questioned why bed side rails were used for the resident and if the bed rails were a restraint.

PSW #130, #125 and RPN #118 indicated that resident #33 used 1/4 length bed rails raised when he/she is in bed, but that they were not be considered a restraint for the resident. Staff indicated that although the bed rails are not considered a restraint, they document hourly checks on the resident to ensure that the bed rails were raised when the resident is in bed.

An interview with the DOC indicated that the 1/4 length bed rails are a restraint for resident #33 and are required to be raised when the resident is in bed. The DOC stated that because the bed rails are a restraint that staff are to complete hourly safety checks on the resident while he/she is in bed. The DOC indicated that staff should be aware of the safety risks associated with bed rails and know the purpose of hourly monitoring. The DOC further stated that an "hourly check list" sheet had been prepared for staff to sign for the monitoring while the resident was in bed with side rails raised.

A review of the resident's "hourly check list" sheet for an identified month, revealed that staff had signed for hourly monitoring between the hours of 7:00 p.m. and 6:00 a.m. daily.

After lunch, on three identified days, the inspector observed resident #33 to be lying in bed, with two 1/4 length bed rails raised. PSW #130 confirmed the above observations and stated resident's rest pattern. The PSW indicated that they do not document hourly checks on the resident in the afternoon as there was no "hourly check sheet" available for documenting the monitoring during this time. An interview with the DOC confirmed that no "hourly check sheet" had been prepared for monitoring for any day time hours between 7:00 am. until 7:00 p.m., and was unaware of resident #33's regular rest pattern.

A review of the written plan of care for resident #33 did not include direction to staff on the safety risks associated with the use of bed rails, including the requirement and purpose of hourly monitoring. The written plan of care did not include the purpose, type, and position of the bed rails, including identification of bed rails as a restraint.
The DOC identified that any bed rails raised and positioned on both bed sides of a resident's bed area a restraint regardless of the length of the bed rail.

Interviews with direct care staff and the DOC revealed a lack of understanding and collaboration amongst each other related to the use and monitoring of bed rails.

The DOC also confirmed that hourly monitoring must be completed and documented for

resident #33 to confirm resident's safety while in bed when the bed rails are in use. Interviews with direct care staff revealed a lack of awareness and collaboration amongst staff on the requirement and purpose of hourly monitoring.

The DOC confirmed that all restraints require a physician's order and that the physician's order had not been obtained for the resident's bed rails. The DOC further confirmed that the development and the implementation of the plan of care had not been completed collaboratively to ensure that the different aspects of care are consistent with and complement each other. [s. 6. (4) (b)]

6. The licensee failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

A review of the written care plan for resident #02 identified the following focuses related to transferring and toileting:
1. Requires two person assistance for the entire process of toileting,
2. Requires two person assistance for all transfers,
3. Requires two person assistance for transporting the resident in his/her wheelchair to and from meals and activities.

The inspector observed on an identified date, resident #02 wheeling him/herself to the washroom and transfer him/herself to the toilet independently.
Interview with PSW #101 and RPN #123 confirmed the resident did not currently require two staff to transfer and that the resident is able to transport him/herself to the dining room for meals. The staff confirmed that the resident was not reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

7. A review of the written care plan for resident #01 identified the following focus:
Two staff are to provide assistance in toileting four times per day at 10:30 a.m., 1:30 p.m., 4:00 p.m., and 8:00 p.m., using a mechanical lift.
During an interview the resident revealed the only scheduled toileting time is at 4:00 p.m., otherwise he/she will use his/her call bell to call the PSW when he/she required toileting. PSW #131 confirmed the resident is toileted at 4:00 p.m., and will ring his/her call bell when he/she required toileting.
PSW #131 and registered staff #107 confirmed during interviews that the resident was not reassessed and the plan of care reviewed and revised when the resident's care

needs change or care set out in the plan is no longer necessary. [s. 6. (10) (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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions and that the physical devices used are well maintained.

At identified times on four identified dates, resident #03 was observed to be reclined in a tilt wheelchair with a seat belt attached to the chair, buckled and resting on the resident's abdomen. From the side view the seat belt was observed to be loose when viewed from the side, with a slack portion of the belt hanging down on the right side of the chair. Resident #03's seat belt manufacturer was identified.

On an identified date, while observing resident #03, an interview with PSW #100 revealed that the seat belt had been correctly applied on resident #03 and indicated that the seat belt is to be kept loose for his/her comfort. The PSW indicated that the seat belt is used to prevent the resident from falling out of the chair and therefore, is a restraint for the resident. RPN #102 interview, when questioned if resident #03's seat belt had been correctly applied, responded "yes".

On the same identified date, the resident's seat belt was observed with the DOC and the DOC confirmed that the seat belt was a restraint and stated that the seat belt appeared to be loose he/she needed to consult with the PC. The PC is responsible for the

coordination of wheelchair and walker assessments, including restraints. Within a short while, the program coordinator arrived and observed the resident's seat belt with inspectors and the DOC. The program coordinator indicated that the seat belt for the resident had been applied too loosely. When questioned as to the appropriate fit of the seat belt, and if the fit of the seat belt was in accordance with manufacturers instructions, the PC revealed an unawareness of manufacturer's instructions, but stated that staff would notice that resident #03's belt appeared too loose and would tighten it accordingly. The PC indicated that staff would know to test if the seat belt is fitting appropriately by putting a hand between the seat belt and the resident's body, moving a hand around as a test to see if the seat belt was too tight. The PC confirmed that he/she had not seen manufacturer's instructions for seat belts in the home.

Three days later, at an identified date and time, resident #03 was observed to be reclined in a tilt wheelchair without a seat belt applied. Interview with the PT available in the resident's home area, resulted in the PT applying resident's seat belt and confirming the seat belt was too loose. The PT tightened the belt with effort and indicated that the resident probably loosened the belt.

Direct care staff interviews revealed no knowledge of how to apply any seat belt used in the home. All staff interviews confirmed an unawareness if a seat belt restraint is applied in accordance with manufacturer's instruction and that manufacturer's instructions were not available in the home for any seat belt restraint.

A review of the home's policy- Minimizing restraints # NUR-V-51 Date Sept 10, states that staff must apply the physical device in accordance with any manufacturer's instructions.
Interviews with the DOC, registered staff and PSW confirmed that manufacturer's instructions were not known to be available on site and that manufacturer's instructions for the correct application of resident #03's identified seat belt had not been reviewed by staff. [s. 110. (1) 1.]

2. The licensee has failed to ensure that staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class.

O.Reg 79/10, s 110 (2) 1, has been the subject of a previous non-compliance, whereby resident #33 was confirmed to be using bed rails as a restraint on two identified dates in 2014. The bed rails had not been ordered or approved by a physician or registered nurse in the extended class. Resident #33 was identified in the inspection report

#2014_168202_0028 which was issued to the home on January 27, 2015.

The home's policy Minimizing restraints # NUR-V-51 Date Sept 10, stated when a physical restraint is deemed necessary-a physician's written order is required. The physician must know who the resident is and approve the type of restraint.

The plan of care for resident #33 indicated that the resident is to have two bed rails raised, when the resident is in bed. A review of resident #33's clinical records indicated that the resident provided consent for use of this restraint.

On three identified dates, the inspector observed the resident lying in bed with two bed rails raised. PSW #130 confirmed the above observations and indicated the bed rails are used as restraints to prevent the resident from falling out of bed.

A review of the resident's clinical records indicated that on an identified date, the resident provided verbal consent for use of a restraint, however, the use of a bed rail restraint had not been ordered by the physician or registered nurse in the extended class which was confirmed by the DOC. [s. 110. (2) 1.]

3. At identified times on five identified dates, resident #03 was observed to be reclined in a tilt wheelchair at an approximate 45 degree angle.

An interview with the DOC confirmed that the tilt chair was a restraint for resident #03. Record review and interview with DOC confirmed that there was no order or approval of the physical device by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

4. The licensee has failed to ensure that the resident is monitored while restrained at least every hour by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff.

O.Reg 79/10, s. 110 (2) 1, has been the subject of a previous non-compliance, whereby resident #33 was confirmed to be using bed rails as a restraint on two identified dates in 2014, without being monitored while restrained at least every hour by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff. Resident #33 was identified the inspection report #2014_168202_0028 which was issued to the home on January 27, 2015.

In the afternoon on three identified dates, the inspector observed resident #33 lying in bed with two 1/4 length bed rails raised. PSW #130 confirmed the above observations and indicated that the bed rails were a restraint and are to be raised while the resident is in bed. A review of the resident's clinical records indicated that on an identified date, the resident provided verbal consent for use of the bed rail restraint.

Interviews with PSW #130, #125 and RPN #118 indicated that the resident is to be monitored every hour while in bed to ensure the use of the side rails and confirmed that they document hourly monitoring from 7:00 p.m. to 6:00 a.m. daily.
Staff interviews further revealed that resident #33 goes to bed everyday with an identified sleep pattern. Staff stated that there were no hourly checks documented for this time period while the resident was in bed.

An interview with the DOC confirmed that a "resident hourly checks" monitoring sheet had not included any day time hours from 7:00 a.m. to 7:00 p.m., as the DOC was unaware of resident's identified sleep pattern. The DOC confirmed that the use of the bed rail restraint for resident #33 had not been monitored at least every hour while by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff while restrained. [s. 110. (2) 3.]

5. The licensee has failed to ensure that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

In the afternoon of three identified days, the inspector observed the resident to be lying in bed with two 1/4 length bed rails raised. PSW #130 confirmed the above observations and indicated that the bed rails were a restraint and are to be raised while the resident is in bed.
A review of the resident's clinical records indicated that on an identified date, the resident provided verbal consent for use of the bed rail restraint. Interviews with registered staff indicated that the bed rail restraint used for resident #33 is not reassessed and the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances. [s. 110. (2) 6.]

6. The licensee has failed to ensure that the documentation include what alternatives were considered and why those alternatives were inappropriate for every use of a

physical device to restrain a resident.

Observations on identified dates revealed resident #03 sitting in a tilt wheelchair at a 45 degree angle and with buckled seat belt in place. Interviews with PSW #100 and #101 confirmed that the seat belt and chair positioning were restraints. Record review and interview with staff and the DOC confirmed that there was no documentation related to what alternatives were considered and why those alternatives were inappropriate related to the use of the seat belt and tilt chair restraint for resident #03. [s. 110. (7) 2.]

7. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response.

Observations on identified dates revealed resident #03 positioned in a tilt chair. Staff interviews confirmed that the chair positioning was a restraint for resident #03. Resident's plan of care did not include the use of a tilt chair as a restraint.
The home's policy Minimizing restraints # NUR-V-51 Date Sept 10, states initial assessment for the need of a restraint involves the resident and/or his/her POA, SDM/Family and multidisciplinary discussion/meeting and the assessment documentation-Restraint assessment is completed by program coordinator.
Record review and interviews with the PC and the DOC confirmed that there was no documentation related to assessment, reassessment and monitoring, including resident's response to the use of a tilt chair as a restraint. [s. 110. (7) 6.]

Additional Required Actions:

CO # - 002, 004 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. 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 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 their health status.

Record review identified that resident #02 was at high nutritional risk and that the resident had an 8 per cent unplanned weight loss in one month between month A and month B, when the resident's weight decreased 5.3 kg. The same identified resident had a 10 per cent weight loss over six months in month F when the resident's weight decreased 6.6 kg.

Record review and interviews with the registered dietitian and the DOC confirmed that there was no assessment of the resident's confirmed significant weight loss on month A, and month F, with actions taken and outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. Record review identified that resident #05 was at high nutritional risk and had an 11.7% significant weight loss over 6 months, on month A when resident's weight decreased 5.5 kg.
Interviews with PSW staff revealed that resident #05 eats poorly and doesn't drink well. Interview with the DOC and RD stated that nursing staff complete the weights and enter resident weights into PCC; if the weight is a 2 kilograms difference from the month before, a referral is sent to the RD. Residents are discussed at the weekly interdisciplinary huddles including the RD, DOC, ADOC and MD. The RD stated that discussion of weight changes was a new topic at the huddle meeting and that when residents are discussed she would document a note in the residents chart.

Record review and interview with RD and DOC confirmed that there was no interdisciplinary referral or assessment of the resident's significant weight loss of month A when the residents weight had decreased 5.5 kg with actions taken and outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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 that the home's policy Administration, Documentation and Storage, subject Safe Storage of Medications, Policy #4.8, revision date of July 2014is complied with.

The home's policy Administration, Documentation and Storage, subject Safe Storage of Medications, Policy #4.8, revision date of July 2014, stated that controlled substances must be counted at the change of every shift and with every administered dose.
The inspector reviewed the control substance count sheets in conjunction with the narcotic controlled substance locked storage area. The inspector observed an identified medication to not be located in the controlled substance storage area where the narcotics and controlled substances are kept. An interview with RPN #123 confirmed that the identified medication was not in the controlled substance storage area of the medication cart, however, after consulting with a colleague, was able to find the identified medication in locked box located in the fridge. RPN #123 confirmed that he/she did not count the identified medication at change of shift as in accordance the home's policy.
The home's policy Administration, Documentation and Storage, subject Administering and Documenting Controlled Substances , Policy #4.3, revision date of July 2014, states that the quantity of every controlled substances is verified for accuracy at the change of each shift and with two registered staff members.
The inspector observed resident #15's medication to be in the locked storage box for narcotics and controlled substances, and did not have a shift count sheet identifying the quantity. RPN #123 and DOC interviews confirmed that there was no record sheet to verify the accuracy of the controlled substance count. The DOC and RPN #123 confirmed in interviews that the home's above mentioned policies had not been complied with. [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 the home's policies Administration, Documentation and Storage, subject Safe Storage of Medications, Policy #4.8, and #4.3, revision date of July 2014, is complied with, to be implemented voluntarily.

WN #5: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Abuse Policy Number HR-VII-12 Dated December 2010, or the Guidelines for the Handling of Abuse Policy dated December 2010, contains an explanation of the duty under section 24 to make mandatory reports.

A review of the home's above mentioned policies, states that all staff members are required to report any abuse immediately to the Director of Nursing and Personal Care or the Nurse Manager.
An interview with the DOC confirmed that the above mentioned policies does not contain a full explanation of the duty under section 24 to make mandatory reports as follows:
A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the
Director:
1.Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in
harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Abuse Policy Number HR-VII-12 Dated December 2010 or the Guidelines for the Handling of Abuse Policy dated December 2010, contains an explanation of the duty under section 24 to make mandatory reports, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

On an identified date during an interview with PSW #108 it was revealed that a an identified individual known to resident #05 reported to him/her that the resident stated a staff member was rough during morning care. The PSW directed the identified individual to speak with the nurse. PSW #108 was unaware of the requirement for Mandatory reporting of alleged abuse, stating it's not my role in the home to call the Ministry, and that his/her role is to report it to a nurse.

The DOC confirmed in an interview that he/she had not received a report or had awareness of resident #05's concern about the rough handling by a staff member. PSW #108, who had reasonable grounds to suspect abuse, did not immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

2. During stage 1 resident interviews, resident #01 revealed that the night before a staff member was rough when turning his/her and that it had never happened before. The resident stated that he/she reported it to PSW #108 and #109. An interview with PSW #108 confirmed that the resident had expressed his/her concern and that the resident was upset. PSW #108 stated that he/she reported it to RPN #107. An interview with RPN #107 confirmed that the information was received and that it was forwarded to management.
An interview with the DOC, stated that when a PSW receives a concern from a resident, the PSW would report the concern to the registered staff. The registered staff would advise management of the concern and management would provide a checklist for the registered staff to fill out. The registered staff take the checklist to management and management does a review and investigation as well.
Interviews with the DOC and ADOC confirmed that they had not received a report or had awareness of resident #01 and #05's concern about the rough handling by a staff member.
PSW #108, and RPN #107, who had reasonable grounds to suspect abuse, did not express awareness of the requirement to immediately report the suspicion and the information upon which it was based to the Director. The training provided by the home on mandatory reporting does not include the requirement of all staff to report to the Director if they have reasonable grounds to suspect abuse of a resident by anyone. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a registered dietitian who is a member of the staff of the home:
(a) complete a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition; and
(b) assess the resident's
- nutritional status, including height, weight and any risks related to nutrition care, and
- hydration status, and any risks related to hydration.

The home's Weights-Residents policy, number DTY-V-14, NUR-V-293, dated September 2014, directs registered staff to do the following:

-All weights are documented on the Monthly Weight Record in Point Click Care.
-Weight variances of 2 kg or 5% are reweighed and documented on the Monthly Weight Record by the 10th of the month, indicating + or – and the amount of the variance in

weight.
-Weight variances of 2 kg or greater or 5% change following the reweigh are highlighted on the Monthly Weight Record, documented on the Dietary Communication/Referral Form is initiated and the Dietary Manager/Dietitian is notified and Referral is placed in the Dietitian's folder.

Record review identified that resident #02 was at high nutritional risk. A review of the resident's monthly weights for an identified six month period revealed that the resident had a 3.1 kg unplanned weight loss from month A to B, a 5.3 kg unplanned weight loss from month B to C and a 2.1 kg unplanned weight loss from month C to D. The resident had an 8 per cent unplanned weight loss in one month between month B and C, when the resident's weight decreased 5.3 kg. The same identified resident had a 10 per cent weight loss over six months when the resident's weight decreased 6.6 kg.

An interview with RPN #121 indicated that all residents are monitored monthly for weight differences of 2 kg or more, and are to be referred to the home's dietitian. The RPN confirmed that resident #02 had unplanned weight loss as indicated above and that a dietary referral had not been sent to the home's dietitian. An interview with the dietitian confirmed that a referral had not been received from nursing for the resident's unplanned weight loss and that the unplanned weight loss for resident #02 had not been assessed until month E, during a regular quarterly nutrition assessment. [s. 26. (4) (a),s. 26. (4) (b)]

2. Resident #05 is at high nutritional risk related to health status, weight loss and altered skin integrity. Resident #05 was assessed by the RD in month A. Record review of the RD assessment identified a concern with ongoing weight loss and that resident was refusing nutritional supplements. The resident was at an identified weight in month A. Resident #05 continued to lose weight and resident's intake and weight was not assessed by the RD until month E at the RD's annual nutrition assessment. Resident's weight in month E, had decreased 3 kg.
An interview with the ADOC confirmed that the RD had not assessed resident's ongoing and significant weight loss of month D.
An interview with the RD revealed that nursing had not sent a referral when resident's weight triggered a 10% weight loss over 6 months. [s. 26. (4) (a),s. 26. (4) (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 a registered dietitian who is a member of the staff of the home:
(a) complete a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition; and
(b) assess the resident's
- nutritional status, including height, weight and any risks related to nutrition care, and
- hydration status, and any risks related to hydration, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following is complied with respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes relevant policies, procedures and protocols for the referral of residents to specialized resources where required.
The legislative requirement under the LTCHA, 2007, O.Reg. 79/10 s. 50 (2) (b) states, 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) 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.

The home's skin and wound program, titled, Skin Care and Wound Management, #NUR-III-02, dated June 2010, directs registered staff to do the following:
"Upon discovery of a pressure ulcer, initiated a baseline assessment using a clinically appropriate assessment instrument (e.g. Appendix D: Pressure Ulcer/Wound Assessment Record) from the Registered Nurses' Association of Ontario (RNAO) Toronto Best Practice Implementation Steering Committee". Registered staff interviewed indicated no knowledge of a clinically appropriated assessment instrument for skin and wound assessment used in the home. Staff indicated that documentation is completed within the progress notes under the title of "Wound Care Note". The DOC indicated in an interview that the home's clinically appropriate assessment instrument is the "Wound Care Note" located in the progress notes. The DOC indicated that the above mentioned policy is not reflective of current practice used in the home and does not provide the current direction to registered staff regarding the use of the clinical assessment tool designed for skin and wound assessment.

Upon further review of the home's skin and wound care program, directs staff to make referrals to interdisciplinary members as required (e.g. registered dietitian, physiotherapist), however, the program does not include the procedures and protocols for referring the resident to interdisciplinary members or specialized resources. Registered staff interviews indicated that any residents with altered skin integrity can be referred to the home's RD for nutrition assessment, however, had no knowledge of when to refer. Staff indicated that they may refer to the dietitian if the wound is bad enough and would not refer to the dietitian if the resident only had a skin tear. An interview with the DOC confirmed that the home's skin and wound care program does not include the procedures and protocols for the referral of residents to specialized resources, including the protocols for the referral to the home's dietitian.

The home's Dietary Intervention and Skin Breakdown policy, DTY-V-16, dated August 2010, states "residents identified with Skin Breakdown at the Stage II or more will receive optimal protein, vitamin C and calories to promote wound healing. Dietary Services are directed to review eating habits and weight patterns of residents with Stage II (not healing) or more skin breakdown. The policy did not include protocols for the referral to the dietitian or direction to the dietitian in respect to the nutritional assessment of residents with altered skin integrity as identified in the legislation, including skin breakdown, pressure ulcers, skin tears or wounds.

An interview with the DOC confirmed that the home's Dietary Intervention and Skin

Breakdown policy, does not include the procedures and protocols for the assessment of identified altered skin integrity indicated in the legislation. [s. 30. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following is complied with respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its relevant policies, procedures and protocols for the referral of residents to specialized resources where required, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent receives an assessment that:
includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

A review of the RAI-MDS assessments for resident #02 revealed on an identified month, the resident was continent. The RAI-MDS assessment for the following month, indicated that the resident was occasionally incontinent and that his/her condition of continence had deteriorated. An interview with the RAI-Coordinator indicated that residents are monitored for continence using a three day or six day tracking tool on admission and when there is a change in the resident's continence status. The RAI-Coordinator indicated that residents are monitored using the tracking tool to determine if they are candidates for a restorative toileting plan and was unaware of any clinical assessment tool used in the home for continence assessment. The DOC confirmed in an interview that the home does not have a clinically appropriate assessment instrument that is specifically designed for continence assessment and that resident #02 had not been assessed as in accordance to the legislation. [s. 51. (2) (a)]

2. A review of the RAI-MDS assessments for resident #01 revealed that from resident's admission, and for the two following, the resident was incontinent and had not been assessed using clinically appropriate assessment instrument that is specifically designed for continence assessment. The RAI-Coordinator indicated that she was unaware of any clinical assessment tool used in the home for continence assessment. The DOC confirmed in an interview that the home does not have a clinically appropriate assessment instrument that is specifically designed for continence assessment and that resident #01 was not assessed as required by the legislation. [s. 51. (2) (a)]

3. A review of the RAI-MDS assessments for resident #05 revealed that from and identified date and for the following five years, the resident was incontinent and had not been assessed using clinically appropriate assessment instrument that is specifically designed for continence assessment. The RAI-Coordinator indicated that she was unaware of any clinical assessment tool used in the home for continence assessment. The DOC confirmed in an interview that the home does not have a clinically appropriate assessment instrument that is specifically designed for continence assessment and that resident #01 was not assessed as required by the legislation. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent receives an assessment that:
includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a response to Residents' Council concerns or recommendations is provided in writing within 10 days of receiving the advice.

Minutes of the Residents' and Food Council meeting of January and April 2015 revealed resident food concerns and recommendations. Residents stated preference for homemade cinnamon buns, concerns around the breaded fish being hard, some residents were unable to eat the chicken served on a particular night and there was no coffee served at the morning snack cart. An interview with the nutrition manager revealed that a written response to these concerns and recommendations had not been provided. An interview with the President of Residents' Council, confirmed, that a written response to food concerns and recommendations is not provided unlike the written response provided by the administrator related to other Residents' Council issues. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a response to Residents' Council concerns or recommendations is provided in writing within 10 days of receiving the advice, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered at each meal.

At lunch, on April 24, 2015, the pureed entree choice was served in serving sizes/amounts less than is required by the planned menu. Dietary aide #120 confirmed that the wrong scoop sizes had been used in error for serving the entree. [s. 71. (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 planned menu items are offered at each meal, to be implemented voluntarily.

WN #12: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to resident, prior to performing their responsibilities.

Staff interviews revealed that they had not received training of mandatory reporting under section 24 of the Act, and were unaware of the requirements under the legislation. PSW and registered staff revealed that they have been directed to report concerns to their supervisor or management.

A review of the home's educational program "resident abuse in LTC, understanding and preventing resident abuse" does not include an explanation of mandatory reporting under section 24 of the Act. The training material states,
"Home must immediately report to the MOHLTC Director all suspected or witnessed incidents of abuse...home must immediately investigate, respond and act and report findings/outcomes to MOHLTC Director; it is an offence to discourage or suppress a mandatory report."
The homes Guidelines for the Handling of Abuse Policy December 2010 under section 3.2 Orientation states "all staff will be trained in the Home's abuse policy within the first 30 days of hire, to include what they are expected to do in suspected cases of abuse."
An interview with the ADOC confirmed that the home's policy and training materials do not include an explanation of mandatory reporting under section 24 of the Act, and therefore staff have not received training prior to performing their responsibilities as required. [s. 76. (2) 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 staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to resident, prior to performing their responsibilities, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required.

Record review revealed the following for resident #12:
1. Resident is to receive medication A 30 minutes prior to administering medication B,
2. Medication C is to be sprinkled on his/her food three times a day, and
3. The resident is to receive their medication whole.
On an identified day, during the morning medication pass the inspector observed the medication administration to the resident the following:
1. The medication A was applied and the registered nursing staff administered medication B within one minute of the application.
2. Medication C was not sprinkled on the residents food but was mixed in with the other medication the resident was to receive, and
3. All medication were crushed and not administered whole.

The written care plan identified that the resident continually refused his/her medication to be taken as directed. Observation of the administration of medications for the resident confirmed the above and that he/she refuses to wait for medication A to take effect but wanted the medication B following the application of medication A.
RPN #123 confirmed that he/she did not follow the directions as ordered by the physician as the resident chose to receive his/her medications as observed. RPN #123 and the DOC confirmed that the resident's medication orders had not been reviewed when the resident's condition is assessed and the resident's plan of care was not revised as required. [s. 117. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required, to be implemented voluntarily.

WN #14: 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 are administered to residents in accordance with the directions for use specified by the prescriber.

Record review revealed in resident #12's plan of care that the resident was to receive medication A 30 minutes prior to medication B, to receive his/her medication whole with water and to sprinkle the contents of medication C over his/her food at each meal.

On an identified date, during the morning medication pass, the inspector observed the nurse apply medication A and then within one minute administered medication B, the medication was not given whole but crushed and in jam and the medication that is to be sprinkled in his/her food was placed in the same cup with the crushed medication.

Interviews with a RPN #123 and the DOC confirmed that the medications were not administered in accordance with the directions from the prescriber. [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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.
Interviews with resident #01, #02 and #04 identified that staff do not respond promptly in answering the call bell when they call for assistance.
Interviews with PSW #128 and RPN #132 confirmed the response time to answer a call bell is a maximum of nine minutes.
An audit of the response time report for February 2015, for the three identified residents revealed that when they resident rang their call bells, the response time to answering the call bell was between ten to 55 minutes, on multiple occasions.
Interviews with the ADOC, DOC and ESM manager confirmed that call bells are to be answered within nine minutes and confirmed that any response time above ten minutes is not acceptable or would not be considered safe. [s. 5.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A review of resident #01's bath schedule revealed that he/she is scheduled for a bath on Wednesday and Saturday each week.
On an identified date, the inspector interviewed resident #01 regarding not receiving his/her bath/shower on the previous Saturday or Sunday. The resident stated "a bath was not offered, however, if we miss a bath they make it up on the Sunday, but I didn't get my bath on Saturday or the makeup bath on the Sunday".
Record review of the flow sheets indicated resident refused his/her bath/shower on an identified date. There was no documentation to support that resident was offered or had the makeup bath on Sunday.

Interviews with PSW #133 and the DOC confirmed that if a resident misses a bath they are given a make up bath on the following Sunday. Bathing documentation identified that resident #01 had refused his/her Saturday bath, with no make up bath provided on Sunday. [s. 33. (1)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that they consult regularly with the Residents' Council, at least every three months.

Record review and an interview with the Administrator confirmed that the licensee does not meet regularly, and in any case, at least every three months with the Residents' Council. An interview with the President of Residents' Council, confirmed that the licensee does not meet regularly and stated that the Council doesn't feel connected to the home. [s. 67.]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interviews with the Administrator, Resident Council assistant and President of Residents' Council confirmed that they could not demonstrate that the development and carrying out of the satisfaction survey and acting on its results, included the advice of the Residents' Council. [s. 85. (3)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including the training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.
A review of the home's Abuse Policy Number HR-VII-12 dated December 2010, does not identify the training and retraining requirements for all staff including the training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. An interview with the ADOC confirmed the above. [s. 96. (e)]

WN #20: 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 has failed to ensure that drugs are stored in the medication cart that is used exclusively for drugs and drug-related supplies.

On April 30, 2015, the inspector observed in the drawer of the medication cart on an identified home area resident #03, #11 and #13's eye glasses. The resident's written care plans were reviewed to observe if there were special notations or instructions regarding eye glasses to be kept in the medication cart and confirmed with RPN #121 that there were no instructions to do this.
The RPN #121 and the DOC confirmed that only drugs and drug related supplies should be stored in the medication cart. [s. 129. (1) (a)]

Issued on this 31st day of July, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202), DIANE BROWN (110), VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2015_168202_0006
Log No. / Registre no:	T-1643-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 28, 2015
Licensee / Titulaire de permis :	THE ONTARIO MISSION OF THE DEAF 2395 BAYVIEW AVENUE, NORTH YORK, ON, M2L-1A2
LTC Home / Foyer de SLD :	BOB RUMBALL HOME FOR THE DEAF 1 Royal Parkside Drive, BARRIE, ON, L4M-0C4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shirley Cassel

To THE ONTARIO MISSION OF THE DEAF, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_168202_0028, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

Order / Ordre :

The licensee shall ensure the following are completed for all resident's requiring bed rail restraints:

1. Within one week of receipt of the order, conduct a meeting between management, physiotherapy, and direct care staff from all shifts.

2.The meeting shall allow direct care staff opportunities to collaborate in the development and implementation of the plan of care. The plan of care shall include the different aspects of care, including resident safety risks, bed mobility, positioning while in bed, and the use or no use of a bed rail as a restraint.

Minutes and attendance to be documented and forwarded to valerie.johnston@ontario.ca upon completion.

3. Continue to schedule and conduct management, physiotherapy and direct care staff meetings that allow for such collaboration with each other in the development and implementation of the plan of care, for all resident's requiring a bed rail restraint.

This requirement to be in place for one year upon receipt of this order as evidence of interdisciplinary collaboration for all residents requiring bed rail restraints.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other 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.

LTCHA, 2007, c. 8, s. 6 (4) has been the subject of a previous compliance order for resident #33. Resident #33 was identified in the inspection report #2014_168202_0028 which was issued to the home on January 27, 2015, with a compliance date of April 30, 2015. The home's plan required in the January 27, 2015 compliance order, involving resident #33 was ineffective, as confirmed by the findings below.

The plan of care for resident #33 indicated that the resident's bed is to be in the lowest position while he/she is in bed, and that the bed rails are to be raised as per substitute decision maker (SDM) request. A review of the resident's records

revealed no physician order for the use of bed rails.
Direct care staff were interviewed and revealed inconsistent knowledge of the purpose and use of resident #33's bed rails as follows:

PSW #128 indicated that resident #33 has two 1/4 length bed rails raised when the resident is in bed and that they are not considered to be a restraint for the resident. Staff continued to state that the resident is not able to get out of bed on his/her own with or without the use of the bed rails, is at risk of choking, and that the bed rails are used as a "turning aid" for staff when assisting the resident.

PSW #129 indicated that resident #33 is at risk of sliding out of his/her bed. Staff continued to state that the resident is to have his/her bed low to the ground with 1/4 length bed rails raised. Furthermore, the staff indicated that the bed rails are only used to position pillows allowing the resident to sit up in bed to accommodate his/her preference.

RPN #121 indicated that resident #33 diagnosis placed the resident at risk for choking, that the resident preferred to sit up in bed with bed rails raised. Furthermore, the RPN stated that the bed rails would prevent the resident from falling out of bed, however, if the resident was to fall into the rails, he/she would not be able to position him/herself away from the bed rails. When questioned by inspector if the bed rails are a restraint for the resident, the RPN indicated "no" because hourly checks were not part of the resident's plan of care. The RPN revealed that it was unclear what the bed rails were intended for, as there was no physician order for use of the bed rails which would normally have been in place if the bed rails were considered a restraint.

RPN #120 indicated in an interview that resident #33 used two 1/4 length bed rails that are to be raised when he/she is in bed to prevent him/her from falling out of bed. When questioned whether the bed rails were a restraint, the RPN confirmed he/she was unsure. The RPN further stated that because staff were completing hourly checks, it must indicate that the bed rails are a restraint for the resident.

PSW #125 indicated that resident #33 will lean over in bed into the 1/4 length bed rails but was unsure when questioned why bed side rails were used for the resident and if the bed rails were a restraint.

PSW #130, #125 and RPN #118 indicated that resident #33 used 1/4 length bed

rails raised when he/she is in bed, but that they were not be considered a restraint for the resident. Staff indicated that although the bed rails are not considered a restraint, they document hourly checks on the resident to ensure that the bed rails were raised when the resident is in bed.

An interview with the DOC indicated that the 1/4 length bed rails are a restraint for resident #33 and are required to be raised when the resident is in bed. The DOC stated that because the bed rails are a restraint that staff are to complete hourly safety checks on the resident while he/she is in bed. The DOC indicated that staff should be aware of the safety risks associated with bed rails and know the purpose of hourly monitoring. The DOC further stated that an "hourly check list" sheet had been prepared for staff to sign for the monitoring while the resident was in bed with side rails raised.

A review of the resident's "hourly check list" sheet for an identified month, revealed that staff had signed for hourly monitoring between the hours of 7:00 p.m. and 6:00 a.m. daily.

After lunch, on three identified days, the inspector observed resident #33 to be lying in bed, with two 1/4 length bed rails raised. PSW #130 confirmed the above observations and stated resident's rest pattern. The PSW indicated that they do not document hourly checks on the resident in the afternoon as there was no "hourly check sheet" available for documenting the monitoring during this time. An interview with the DOC confirmed that no "hourly check sheet" had been prepared for monitoring for any day time hours between 7:00 am. until 7:00 p.m., and was unaware of resident #33's regular rest pattern.

A review of the written plan of care for resident #33 did not include direction to staff on the safety risks associated with the use of bed rails, including the requirement and purpose of hourly monitoring. The written plan of care did not include the purpose, type, and position of the bed rails, including identification of bed rails as a restraint.
The DOC identified that any bed rails raised and positioned on both bed sides of a resident's bed area a restraint regardless of the length of the bed rail.

Interviews with direct care staff and the DOC revealed a lack of understanding and collaboration amongst each other related to the use and monitoring of bed rails.

The DOC also confirmed that hourly monitoring must be completed and documented for resident #33 to confirm resident's safety while in bed when the bed rails are in use. Interviews with direct care staff revealed a lack of awareness and collaboration amongst staff on the requirement and purpose of hourly monitoring.

The DOC confirmed that all restraints require a physician's order and that the physician's order had not been obtained for the resident's bed rails. The DOC further confirmed that the development and the implementation of the plan of care had not been completed collaboratively to ensure that the different aspects of care are consistent with and complement each other. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

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. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall:

1. Upon receipt of this order, the licensee shall ensure that the following is completed for resident #33:

a) Staff only apply a physical restraint device that has been ordered or approved by a physician or registered nurse in the extended class.
b) Staff monitor the resident, while restrained, at least every hour by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff.
c) Staff are to ensure that while resident #33 is restrained by a physical device, the resident's condition is reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

2. The licensee shall ensure that all staff caring for residents using a restraint receive training on the purpose and frequency of monitoring a resident while a restraint is in use.

3. Develop, implement and submit a plan to ensure that:

a) Staff only apply a physical restraint device that has been ordered or approved by a physician or registered nurse in the extended class.
b) Staff monitor the resident while restrained at least every hour by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff.
c) While a resident is restrained by a physical device, the resident's condition been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

4. The plan is to include the required tasks, the person responsible for completing the tasks and the time lines for completion.

5. The plan shall be submitted to valerie.johnston@ontario.ca by August 30, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class.

At identified times on five identified dates, resident #03 was observed to be reclined in a tilt wheelchair at an approximate 45 degree angle.

An interview with the DOC confirmed that the tilt chair was a restraint for resident #03. Record review and interview with DOC confirmed that there was no order or approval of the physical device by a physician or registered nurse in the extended class. (110)

2. The home's policy Minimizing restraints # NUR-V-51 Date Sept 10, stated when a physical restraint is deemed necessary-a physician's written order is required. The physician must know who the resident is and approve the type of restraint.

O.Reg 79/10, s 110 (2) 1, has been the subject of a previous non-compliance, whereby resident #33 was confirmed to be using bed rails as a restraint on two identified dates in 2014. The bed rails had not been ordered or approved by a physician or registered nurse in the extended class. Resident #33 was identified in the inspection report #2014_168202_0028 which was issued to the home on January 27, 2015.

The plan of care for resident #33 indicated that the resident is to have two bed rails raised, when the resident is in bed. A review of resident #33's clinical records indicated that the resident provided consent for use of this restraint on an identified date.

On three identified dates, the inspector observed the resident lying in bed with two bed rails raised. PSW #130 confirmed the above observations and indicated the bed rails are used as restraints to prevent the resident from falling out of bed.

A review of the resident's clinical records indicated that on an identified date, the resident provided verbal consent for use of a restraint, however, the use of a bed rail restraint had not been ordered by the physician or registered nurse in the

extended class which was confirmed by the DOC.

(202)

3. The licensee has failed to ensure that the resident is monitored while restrained at least every hour by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff.

O.Reg 79/10, s. 110 (2) 1, has been the subject of a previous non-compliance, whereby resident #33 was confirmed to be using bed rails as a restraint on two identified dates, without being monitored while restrained at least every hour by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff. Resident #33 was identified the inspection report #2014_168202_0028 which was issued to the home on January 27, 2015.

In the afternoon of three identified dates, the inspector observed resident #33 lying in bed with two 1/4 length bed rails raised. PSW #130 confirmed the above observations and indicated that the bed rails were a restraint and are to be raised while the resident is in bed. A review of the resident's clinical records indicated that on an identified date, the resident provided verbal consent for use of the bed rail restraint. Interviews with PSW #130, #125 and RPN #118 indicated that the resident is to be monitored every hour while in bed to ensure the use of the side rails and confirmed that they document hourly monitoring from 7:00 p.m. to 6:00 a.m. daily.
Staff interviews further revealed that resident #33 goes to bed everyday at preferred times. Staff stated that there were no hourly checks documented for this time period while the resident was in bed.

An interview with the DOC confirmed that a "resident hourly checks" monitoring sheet had not included any day time hours from 7:00 a.m. to 7:00 p.m., as it was assumed the resident did not use his/her bed during the day. The DOC confirmed that the use of the bed rail restraint for resident #33 had not been monitored at least every hour while by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff while restrained.

(202)

4. The licensee has failed to ensure that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

In the afternoon of three identified dates, the inspector observed the resident to be lying in bed with two 1/4 length bed rails raised. PSW #130 confirmed the above observations and indicated that the bed rails were a restraint and are to be raised while the resident is in bed.

A review of the resident's clinical records indicated that on an identified date, the resident provided verbal consent for use of the bed rail restraint. Interviews with registered staff indicated that the bed rail restraint used for resident #33 is not reassessed and the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

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. 69. 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.

Order / Ordre :

The licensee shall:

1. Within one week of receipt of this order, establish and implement a process for staff to identify resident's with weight changes.

2. Within three weeks of receipt of this order, assess all residents identified with weight changes of 5 per cent of body weight, or more, over one month; 7.5 per cent of body weight, or more, over three months; 10 per cent of body weight, or more, over 6 months or any other weight change that compromises the resident's health status.

3. To demonstrate an interdisciplinary approach in the assessment of residents with weight changes.

4. To ensure that actions are taken and outcomes are evaluated.

Grounds / Motifs :

1. The licensee has failed to 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
3. A change of 10 per cent of body weight, or more, over 6 months

Record review identified that resident #05 was at high nutritional risk and had an 11.7% significant weight loss over 6 months, on month A when resident's weight decreased 5.5 kg.
Interviews with PSW staff revealed that resident #05 eats poorly and doesn't drink well.
Interview with the DOC and RD stated that nursing staff complete the weights and enter resident weights into PCC; if the weight is a 2 kilograms difference from the month before, a referral is sent to the RD. Residents are discussed at the weekly interdisciplinary huddles including the RD, DOC, ADOC and MD. The RD stated that discussion of weight changes was a new topic at the huddle meeting and that when residents are discussed she would document a note in the residents chart.

Record review and interview with RD and DOC confirmed that there was no interdisciplinary referral or assessment of the resident's significant weight loss of month A when the residents weight decreased 5.5 kg with actions taken and outcomes evaluated. (110)

2. Record review identified that resident #02 was at high nutritional risk and that the resident had an 8 per cent unplanned weight loss in one month between month A and month B, when the resident's weight decreased 5.3 kg. The same identified resident had a 10 per cent weight loss over six months in month F when the resident's weight decreased 6.6 kg.

Record review and interviews with the registered dietitian and the DOC confirmed that there was no assessment of the resident's confirmed significant weight loss on month A, and month F, with actions taken and outcomes evaluated.
(202)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall complete the following:

1. Upon receipt of this order, obtain any manufacturer's instructions for all seat belt restraints used in the home.

2. Upon receipt of this order, all staff must receive training on the correct application of all seat belt restraints used within the home in accordance with any manufacturer's instructions.

3. All staff must apply all seat belt restraints in accordance with any manufacturer's instructions used in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions and that the physical devices used are well maintained.

At identified times on four identified dates, resident #03 was observed to be reclined in a tilt wheelchair with a seat belt attached to the chair, buckled and resting on the resident's abdomen. From the side view the seat belt was

observed to be loose when viewed from the side, with a slack portion of the belt hanging down on the right side of the chair.
Resident #03's seat belt manufacturer was identified.

On an identified date, while observing resident #03, an interview with PSW #100 revealed that the seat belt had been correctly applied on resident #03 and indicated that the seat belt is to be kept loose for his/her comfort. The PSW indicated that the seat belt is used to prevent the resident from falling out of the chair and therefore, is a restraint for the resident. RPN #102 interview, when questioned if resident #03's seat belt had been correctly applied, responded "yes".

On the same identified date, the resident's seat belt was observed with the DOC and the DOC confirmed that the seat belt was a restraint and stated that the seat belt appeared to be loose he/she needed to consult with the PC. The PC is responsible for the coordination of wheelchair and walker assessments, including restraints. Within a short while, the program coordinator arrived and observed the resident's seat belt with inspectors and the DOC. The program coordinator indicated that the seat belt for the resident had been applied too loosely. When questioned as to the appropriate fit of the seat belt, and if the fit of the seat belt was in accordance with manufacturers instructions, the PC revealed an unawareness of manufacturer's instructions, but stated that staff would notice that resident #03's belt appeared too loose and would tighten it accordingly. The PC indicated that staff would know to test if the seat belt is fitting appropriately by putting a hand between the seat belt and the resident's body, moving a hand around as a test to see if the seat belt was too tight. The PC confirmed that she had not seen manufacturer's instructions for seat belts in the home.

Three days later, at an identified date and time, resident #03 was observed to be reclined in a tilt wheelchair without a seat belt applied. Interview with the PT available in the resident's home area, resulted in the PT applying resident's seat belt and confirming the seat belt was too loose. The PT tightened the belt with effort and indicated that the resident probably loosened the belt.

Direct care staff interviews revealed no knowledge of how to apply any seat belt used in the home. All staff interviews confirmed an unawareness if a seat belt restraint is applied in accordance with manufacturer's instruction and that manufacturer's instructions were not available in the home for any seat belt

restraint.

A review of the home's policy- Minimizing restraints # NUR-V-51 Date Sept 10, states that staff must apply the physical device in accordance with any manufacturer's instructions.
Interviews with the DOC, registered staff and PSW confirmed that manufacturer's instructions were not known to be available on site and that manufacturer's instructions for the correct application of resident #03's identified seat belt had not been reviewed by staff. (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 28th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

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