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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 6, 2016	2016_337581_0006	013276-16	Resident Quality Inspection

Licensee/Titulaire de permis

WATERDOWN LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

ALEXANDER PLACE
329 Parkside Drive P. O. Box 50 Waterdown ON L0R 2H0

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

DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528), LEAH CURLE (585)

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): May 5, 6, 10, 11, 12, 16, 17, 18, 19, 20, 25, 2016.

The following inspections were completed concurrently with this RQI. Complaint Inspection log #017766-15 related to responsive behaviours and personal care, log #026037-15 related to responsive behaviours, log #031247-15 related to personal care, log #034527-15 related to personal care and Critical Incident Inspections log #002124-15, log #034045-15, log #001942-16, log #008158-16, log #008520-16 and log #009867-16 related to responsive behaviours and Follow-up log #020541-15 to 2015_205129_007 /H-002260-15 CO#001 s.6(10) related to plan of care

During the course of the inspection, the inspector(s) spoke with Administrator #001, Previous Administrator #002, Director of Care (DOC), Co- Directors of Care, Registered Nurse (RN), Registered Practical Nurses (RPN), Staff Educator #002, Physiotherapist (PT), Restorative Care Coordinator, Nutrition Manager, Resident and Family Coordinator, Personal Support Workers (PSW), housekeeping staff, dietary staff, private care giver, residents and families.
The inspectors also toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records and log reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2015_205129_0007	581

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. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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 was a written plan of care for each resident that set out the planned care for the resident.

A. On May 5, 10 and 11, 2016, resident #008 was observed reclined in a tilt chair.

Review of their written plan of care did not include the use of a tilt chair. PSW #109 and registered staff #108 reported the resident used the tilt for comfort and positioning; however, it was not included in the kardex or care plan, which were documents used by staff that set out the planned care for the resident. Registered staff #106 confirmed the resident had used the tilt chair since August 2014; however, confirmed it was not included in the written plan of care.

B. On May 6, 10 and 12, 2016, resident #011 was observed with a device applied. Review of the written plan of care did not include the use of the device. Resident #011 reported they were able to release the device on their own. Registered staff #107 stated the resident was able to release the device; however, confirmed the device was not included in their written plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. Review of the Minimum Data Set (MDS) assessment for resident #007 completed in March 2016, identified they required supervision with toileting; however, the Resident Assessment Protocol (RAP) in the same time period indicated the resident required extensive assistance with toileting. Interview with staff educator #002 confirmed that the MDS assessment and RAPS were not consistent with each other.

B. Review of the MDS admission assessment for resident #014 in November 2015, indicated they required limited assistance with activities of daily living (ADL's) for dressing and toileting. In a subsequent MDS assessment completed in February 2016, they were assessed as requiring extensive assistance with dressing and toileting; however, coded as no change in their ADL function. Interview with staff educator #002 confirmed the resident had a decline in two or more ADL's in February 2016 and the MDS assessments did not complement each other.

C. A review of the MDS assessment for resident #005 completed in April 2016, indicated they had a fall in the last 30 days. Review of the progress notes in April and March of 2016, revealed the resident had not fallen. Interview and record review with registered staff #101 identified that they had not fallen this year and confirmed that the MDS assessment and the plan of care were not consistent with each other related to falls in the past 30 days. (581)

D. A review of the MDS assessment for resident #010 completed in April 2016, identified they had not fallen in the last 30 days and the MDS assessment completed in January 2016, indicated they had not fallen the the past 31-180 days; however, review of progress notes and post falls assessments identified that the resident had fallen on an identified day in March 2016 and an identified day in November 2015. Interview with Staff Educator #002 confirmed that the MDS assessments were not consistent or collaborated with the post falls assessments. (581)

E. Review of the MDS assessment for resident #060 completed in January 2016, indicated they did not have an injury in the past 180 days; however, review of the progress notes and x-ray reports identified that they sustained an injury on an identified day in December 2015. Interview with staff educator #002 confirmed that the resident had an injury and that the MDS assessment was not consistent with the x-ray reports and physician notes. (581)

F. In May 2015, the MDS Assessment for resident #005 identified that the resident was occasionally incontinent of bladder (more than two times per week). In August 2015, the MDS Assessment identified the resident was frequently incontinent of bladder (incontinent daily, with some control present); however, no change was identified in urinary continence. Interview with Staff Educator #002 confirmed that from May to August 2015, the resident did have a deterioration in urinary continence related to the type of continent product being used; however, was not coded appropriately. The MDS Assessment from August 2015, did not complement the MDS Assessment from May 2015, in identifying a deterioration in urinary continence for resident #005. (528) [s. 6. (4) (a)]

3. The licensee failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

On an identified day in June 2015, resident #044 was found with an object on their wheelchair, while the resident was seated in the wheelchair. It was documented by registered staff that two staff were required to remove the object. Two days after the incident occurred the same staff member assessed the resident to having an injury. Review of the plan of care did not include any documentation to support that the resident's substitute decision maker (SDM) was notified of the incident. On an identified day in June 2015, when the SDM came into visit with the resident, the injury was observed and it was not until the SDM questioned staff as to the origin of the injury that

the home investigated the incident. The SDM was not given an opportunity to participate in the resident plan of care, related to the incident and injury in June 2015, as confirmed by the DOC. [s. 6. (5)]

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

A. On an identified day in March 2016, resident #042 complained of discomfort and the following day was diagnosed with an infection. In March 2016, new orders were received from the physician, including but not limited to, monitoring the resident for several days. Review of the plan of care revealed that the resident was only monitored once. Interview with registered staff #106 confirmed that the resident was not monitored for several days as required by the physician.

B. Resident #022's plan of care for bathing, effective on an identified day in April 2015, indicated the resident had an impairment with specific interventions in place prior to receiving care. On an identified day in September 2015, documentation revealed PSW #139 provided care to resident #022. PSW #139 reported in an interview the resident became upset during care. PSW #139 stated they completed their care quickly and confirmed they did not know how to approach the resident when providing care as they did not review the resident's plan of care prior to providing their care. Interview with Co-DOC #106 confirmed the resident was upset after receiving care by PSW #139 and that the care set out in the plan of care was not provided to the resident related to bathing. (585)

C. In June 2015, resident #044 was seated in their wheelchair in their room, unsupervised. Registered staff documented an object was found on their wheelchair, while the resident was seated in the wheelchair and that two staff were required to remove the object. The plan of care for resident #044 identified the resident was at high risk for falling related to medications, cognitive deficit, a specific diagnosis and attempts of rolling out of bed. Interventions to ensure the resident's safety included but were not limited to, not to leave the resident alone in their room and the written care plan directed staff to closely monitor the resident. Interview with DOC confirmed that staff caring for the resident was not regular staff and did not follow the plan of care, leaving the resident unsupervised in their room. [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the

resident's care needs changed or the care set out in the plan was no longer necessary.

A. Resident #007's plan of care stated they preferred to wear a pull-up style continence product with a pad. Interview with resident #007, PSW #110 and PSW #135 reported the resident used a pull-up product; however, was changed to a brief for improved containment. PSW #110 stated continence products used were noted either on the plan of care or the Medical Mart continence product list in the home area. Review of the Medical Mart continence product list did not include the resident or the continent product they required. Interview with staff educator #002 confirmed the resident's plan of care was not revised when the residents care needs changed related to continence products.

B. Resident #004's MDS assessment completed in March 2016, identified they required extensive assistance with dressing and toileting during the assessment review date (ARD) period. Review of the resident's plan of care indicated they required set up help for toileting and assistance to assemble clothing and then dressed themselves. Interview with PSW #121 and PSW #117 reported the resident required extensive assistance with dressing and toileting on day and evening shifts. Staff educator #002 confirmed the resident's plan of care was not reviewed and revised when the resident's care needs changed.

C. Review of resident #003's written plan of care indicated they required one three quarter bed rail raised when in bed for bed mobility. Interview with the resident and PSW #119 stated they did not have a bed rail raised when in bed. Review of the physician's order in April 2016, indicated the bed rail was to be discontinued. Interview with Restorative Care Coordinator (RCC) confirmed that the written plan of care was not reviewed and revised when the care set out in the plan was no longer necessary. (581)

D. Review of resident #003 current written plan of care indicated they were transferred side by side with two staff from bed to chair in the morning. Interviews with PSW #115 and PSW # 116 stated that the resident was transferred in and out of bed with one staff assistance and often self- transferred. Interview with RCC stated that the resident was transferred with one staff in and out of bed and that the plan of care was not reviewed and revised when the care needs changed related to transfers. (581) [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that set out the planned care for the resident, that staff and others involved in different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, that the resident, the SDM, if any, and the designate of the resident / SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care, that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs changed or the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's Falls Prevention and Management Program, version 2, last revised March 18, 2015, indicated that when a resident had fallen the registered staff would initiate a Head Injury Routine (HIR) if the head injury was evident or if the fall was unwitnessed

and a fall follow-up progress note was completed for at least three shifts following the incident.

A. Resident #003 fell on the following dates and a post up follow up note was not completed for three shifts as follows;
i. On an identified day in January 2016, on night shift.
ii. On an identified day in February 2016, on night shift.
iii. On an identified day in March 2016, on day and night shift
iv. On an identified day in April 2016, on night shift.

Interview with registered staff #113 confirmed that staff were not consistently completing all post falls follow up note for three shifts following resident #003 falls.

B. Resident #003 sustained an unwitnessed fall on an identified day in May, April, March and February, 2016. Review of the plan of care indicated that the HIR was not completed on all shifts post fall and was not initiated after the fall in February 2016. Interview with registered staff #113 confirmed that the HIR was not completed post three falls and was not initiated post fall in February 2016 and confirmed the home's policy was not complied with.

C. Resident #010 fell on the following dates and a post fall follow up note was not completed for three shifts as follows;
i. On an identified day in January 2016, on day and night shift.
ii. On an identified day in March 2016, on evening and night shift.

Interview with Staff Educator #002 confirmed that the post fall follow up note was not consistently completed post falls for resident #010 and the home did not comply with their falls prevention and management policy.

D. The plan of care for resident #040 identified that the resident was at risk for falls and had ongoing frequent falls related to medication use and specific diagnoses. From February to June 2015, resident #040 had multiple falls. Following an immediate assessment of the resident it was noted that post fall documentation did not consistently include fall follow up notes for three shifts following the falls, as required in the homes policy:
i. On an identified day in February 2015, fall follow up notes were not completed for one out of three shifts and after another fall in February 2015, fall follow up notes were not completed.

ii. On an identified day in March 2015, fall follow up notes were not completed for two out of three shifts and not completed for one out of three shifts after two more falls on identified dates in March 2015.
iii. On an identified day in April 2015, fall follow notes were not completed for two out of three shifts.
vii. On an identified day in May 2015, fall follow up notes were not completed.
viii. On an identified day in June 2015, fall follow up notes were not completed for one out of three shifts.

Interview with registered staff #106 confirmed that staff were not consistently completing fall follow up notes following resident #040's falls as required in the homes policy. (528)

E. The home's policy, Transfers, Lifts and Carries Guidelines version 2, revised date January 28, 2014, indicated pictures that illustrated the amount of assistance required for transfers and lifts and were to be posted above residents' bed. The logo was to to used as the appropriate guide to resident's capabilities with transfers and lifts. Interview with the Restorative Care Coordinator (RCC) and through observation of resident's room identified that there were no transfer logos at bedside indicating the resident's assessed transfers. Interview with DOC confirmed that the home had not posted transfer logos at bedside and they did not comply with their policy.

F. The Head Injury Routine policy, version two, revised July 2014, outlined the following directions for staff: "in the event of a resident emergency related to head injury, sustained as a result of injury, fall or unknown origin: the DOC will initiate an investigation of the cause of the injury, registered staff will complete a full assessment and initiate the head injury routine form, monitor for signs and symptoms of head injury, assess for clinical signs of acute subdural hematoma associated with major trauma (up to two weeks post incident), notify physician and POA."

On an identified day in June 2015, registered staff documented the resident had sustained an injury. Review of the plan of care did not include any assessment of the resident related to the injury or any investigation as to the cause of the injury until several days later, when the SDM observed the injury and expressed concerns to the staff. Interview with the DOC confirmed that registered staff did not assess the resident, as required in the HIR policy for an injury of unknown origin and investigation of the cause was not initiated until several days after the injury was first documented. (528)

G. The Continence Care and Bowel Management Program, last revised, July 2014,

directed registered staff to complete an "assessment for continence" under Point Click Care assessments. Referrals and additional "assessment for continence" was to be completed with any decline in bowel and/or bladder continence indicated in completing Resident Assessment Instrument (RAI)-MDS.

The MDS Assessment from August 2015, for resident #002 identified that the resident had and increase in coding for both bladder and bowel continence when compared to the previous MDS Assessment. Review of the plan of care and interview with staff educator #002 confirmed that the resident had an increase in incontinence or deterioration in both bladder and bowel continence; however, did not include an "assessment for continence". Interview with Staff Educator #002 confirmed that the home had not completed the "assessment for continence" and it was only completed on the admission of resident #002. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

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

A. On an identified day in January 2016, PSW #150 was providing morning care to resident #045. At noon that same day, RPN #151 and PSW #152 working on the same

home area reported allegations of staff to resident abuse between PSW #150 and resident #045 to management.

i. Review of the home investigation notes identified that between 0730 and 0830 hours, PSW #150 was providing morning care to resident #045 and was unable to dress the resident. PSW #150 transported the resident in their wheelchair into the hallway, only partially dressed and called for PSW #152 for assistance. As PSW #150 walked away, RPN #151 heard them call the resident a name using offensive language and referred to the resident in a demeaning way. The resident was then wheeled into a co-residents bathroom to finish dressing. PSW #152 documented that after dressing the resident, PSW #150 pushed the resident back into their chair, referred to the resident in a demeaning way and called them an offensive name.
ii. Interview with RPN #151 identified that between the hours of 0730 and 0830, they had heard yelling coming from down the hallway, which sounded like PSW #150, but the RPN was administering medications and could not see what was happening. RPN #151 confirmed that shortly after the yelling was heard, PSW #150 wheeled the resident out into the hallway and they were only partially dressed leaving them exposed. RPN #151 confirmed that they overheard the PSW refer to the resident using offensive language and referred to the resident in a demeaning way. RPN #151 described the PSW as "frustrated" and "stressed". RPN #151 confirmed that PSW #150 continued to provide other residents care that morning after the incident, and although they continued to be "frustrated" no other incidents were witnessed.
iii. Interview with PSW #152 identified that they were providing care to a co-resident when they heard PSW #150 calling for help. When PSW #152 observed the resident seated in their wheelchair, partially dressed, leaving them exposed. PSW #152 indicated that PSW #150 reported to them that the resident was resisting care; however, when PSW #152 entered the hallway they stated the resident appeared to be calm. PSW #152 confirmed that after dressing the resident, PSW #150 pushed the resident back into their wheelchair, looked at the resident and called them a name using offensive language and described them in a demeaning way. PSW #152 confirmed that PSW #150 continued to be "frustrated" after the incident and provided care to other residents.
iv. Interview with the Administrator #002 stated that they observed PSW #150 the day before the incident looking "stressed" and they had requested the DOC to meet with the staff member. The Administrator denied receiving any reports, prior to the incident, related to PSW #150. A meeting between PSW #150 and the DOC occurred the day before the incident and the PSW indicated everything was "fine".
v. Investigation notes documented that registered staff #106 was made aware of allegations at approximately 1200 hours, at which time, PSW #150 was removed from

the floor.
vi. Interview with DOC confirmed that as a result of the home's investigation, allegations of abuse were substantiated. A statement from PSW #150 dated on an identified day in January 2016, documented that PSW #150 took full responsibility for the incident.

The home did not protect resident #045 from verbal and physical abuse. PSW #150 continued to provide care to the resident when two staff members working on the same home area witnessed both verbal and physical abuse. Interview with RPN #151 confirmed that they did not intervene and PSW #150 continued to provide care to resident #045 and other co-residents that morning. The RPN #151 identified that, although they had received training, they were new to the role and were unsure of how to act. The RPN #151 wanted to meet with PSW #152 before reporting to registered staff #106. (528)

B. In March 2016, an after-hours page was made to the Ministry of Health and Long-Term Care (MOHLTC) regarding allegations of staff-to-resident abuse. Review of the home's incident report and investigation notes revealed written allegations were brought forth to the home that stated PSW #139 wanted to provide care to resident #021 in a way that was not acceptable to them, PSW #139 called them an inappropriate name and provided rough care.

The home's internal investigation notes revealed that resident #021 was cognitive aware and their plan of care outlined specific direction as to how their personal care was to occur. When the home interviewed resident #021, they reported PSW #139 wanted to provide care in a way that was unacceptable to them, that they refused and PSW # 139 called resident #021 an unkind name. The resident reported they no longer wanted the PSW to provide direct care. On an identified day in May 2016, resident #021 repeated the same information in an interview with Long Term Care (LTC) Homes Inspector #585 and stated the incident caused them to be upset.

On an identified date in May 2016, PSW #139 reported to LTC Homes Inspector #585 they were aware of the specific interventions on the resident's plan of care for personal care; however, confirmed they chose not to follow it in an attempt to save time and the resident clearly refused.

Results of the home's investigation revealed the PSW #139 received discipline as it was documented in the file as "a potential abusive situation and lack of understanding of the resident's plan of care". Inspection of PSW #139's staff discipline record revealed they

also had a history of verbal abuse to residents as well as failure to follow a resident's plan of care, as confirmed by the DOC. [s. 19. (1)] (585)

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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: 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 was 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.

The plan of care for resident #047 identified that the resident required total assistance with bathing, preferred a bath and was bathed twice a week. Bathing records from February to May 2016, did not include a documented bath on scheduled days on two identified dates in March and April 2016; instead, bathing was documented as not applicable. Furthermore, no additional "make-up" baths were provided until the next scheduled bathing day. Interview with PSW #111 and #141 confirmed that not applicable meant that they did not have the time to bath the resident. On two identified days in March and April 2016, resident #047 did not receive their scheduled baths and therefore were not provided the minimum requirement for bathing. [s. 33. (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 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified day in June and two identified dates in July 2015, resident #044 was noted to have new areas of altered skin integrity. Review of the plan of care did not include a referral to the Registered Dietitian (RD). In the quarterly review from May and August 2015, the RD noted their skin was intact. Interview with DOC confirmed a referral was not sent to the RD related to the resident's new altered skin integrity in June and July 2015 and as a result, the RD assessment was not based on the residents ongoing altered skin integrity. [s. 50. (2) (b) (iii)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The plan of care for resident #40 identified that the resident had responsive behaviours towards staff and co-residents. The resident was also noted to have a specific diagnosis and cognitive impairment related to dementia and was receiving routine analgesia for pain. In December 2014 and February 2015, staff documented pain as a trigger for the resident's responsive behaviours; and as a result, an opioid analgesia was ordered on an as needed basis.

i. The Pain Management Program , last revised March 2016, stated that every resident "is screened for pain as deemed necessary by the registered staff. Screening will include use of self report of pain if possible with numeric or verbal rating scale, or behavioural monitoring (Pain Assessment in Advanced Dementia Pain-AD) if not able to report".

ii. Review of resident #040's plan of care did not include consistent assessments of pain when the resident displayed responsive behaviours. Furthermore, when pain was assessed by the registered staff the tool used was not clinically appropriate for a resident with advanced dementia, as the Pain Assessment in Advanced Dementia (Pain-AD) tool was not used.
a. In February 2016, the resident had responsive behaviours towards co-residents and documentation did not include any pain assessment after each incident.
b. On an identified day in February 2016, registered staff documented that the resident had no complaints of pain and the Pain-AD tool was noted used.
c. On another identified day in February 2016, registered staff document that the resident "shows no signs of pain" but documented the resident was demonstrating responsive behaviours.
d. On an identified day in April 2015, registered staff documented the resident was demonstrating responsive behaviours, no pain assessment completed.
e. On an identified day in May 2015, registered staff documented the resident was aggressive with staff, no pain assessment completed.
f. On another identified day in May 2015, resident refused physiotherapy, no pain assessment completed.
g. On an identified day in July 2015, registered staff documented the resident was demonstrating responsive behaviours, no pain assessment documented.
h. On an identified day in August 2015, registered staff documented that the resident denied pain when asked but on the same day behavioural mapping notes identified the resident was restless and wandering and no Pain-AD was completed.

Only one Pain-AD assessment was included in the resident's clinical health record. Interview with registered staff #106 confirmed that pain was a trigger for the resident's behaviours; however, the resident's pain was not consistently assessed using a clinically appropriate assessment tool, the Pain-AD tool, when these behaviours were present. [s. 52. (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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The plan of care for resident #40 identified that the resident had responsive behaviours towards staff and co-residents. The resident was also noted to have a specific diagnosis and cognitive impairment related to dementia and was receiving routine analgesia for pain. In December 2014, registered staff documented pain as a trigger for behaviours and that routine pain medications were effective.

i. In February 2016, the resident demonstrated responsive behaviors towards co-residents and documentation did not include any pain assessment after each incident. As a result of the incidents, the resident was referred to Behavioural Supports Ontario

(BSO), who documented moderate pain as a trigger for responsive behaviours and pain medication orders were increased to include an additional medication to be given on as needed basis.
ii. On an identified day in April 2016, registered staff documented the resident displayed a responsive behaviour; however, no pain assessment completed. In May 2015, the resident was documented as displaying responsive behaviours, no pain assessment was documented.
iii. On an identified day in May 2015, the resident displayed a responsive behaviour towards a co-resident causing injury, no pain assessment was completed.

Interview with registered staff #106 confirmed that pain was a trigger for the resident's behaviour; however, the resident's pain was not consistently assessed when these behaviours were present. Although, registered staff and BSO documented pain as a trigger and changes were made to pain medications, interventions were not developed to ensure that the resident pain was assessed routinely. The resident continued to display responsive behaviours and the risk of altercations towards co-residents was not minimized.

B. The plan of care for resident #043 identified that the resident had a history of responsive behaviours towards co-residents and interventions were in place. The resident was also noted to be in tilted wheelchair and depended on staff for mobility and positioning.

In December 2015, staff placed resident #043 beside co-resident #002, within arms length. Resident #002 was also noted to be in a wheelchair and dependent on staff for mobility and positioning. As a result of placing resident #043 and #002 beside each other, both residents displayed behaviours resulting in an injury to resident #002. Interview with RPN #130 confirmed that staff did not implement interventions to keep resident #043 away from other residents and did not minimize the risk of altercations between resident #043 and #002. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents.

Resident #024's plan of care stated they required total assistance with eating. On May 5, 2016, during an observation of the afternoon nourishment pass, the resident was observed reclined in their tilt wheelchair, receiving assistance drinking by PSW #134. PSW #134 reported the resident was not seated upright and the Nutrition Manager (NM) confirmed they were to be in an upright position when eating and drinking. [s. 73. (1) 10.]

2. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents.

On May 5 and 17, 2016, resident #025 was observed sitting in their wheelchair with their upper chest parallel to the table and eating soup on their lap. On both days, the resident reported they would be more comfortable if the table was lower. Interview with PSW #123, registered staff #101 and the NM all reported they were unaware the resident was uncomfortable; however, the FSM stated they were looking into obtaining adjustable tables to better meet the needs of residents. [s. 73. (1) 11.]

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 proper techniques are used to assist residents with eating, including safe positioning of residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. On May 5, 2016 at 1150 hours, a medication cart on home area three was observed unlocked outside the dining room, as the lock was not completely pushed in. No registered staff were present for an unidentified period of time. Registered staff #101 returned from the dining room and confirmed the cart was unlocked and should have been locked.

B. On May 17 2016, at approximately 1600 hours, an unlocked medication cart was observed in the doorway of the activity room in home area three. Registered staff #145 was in the activity room and exiting to return to the cart as the observation was made and subsequently noted to open the cart without a key. At 1630 hours, the cart was found outside the dining room and appeared unlocked. Registered staff #145 was observed exiting the dining room as the inspector approached the cart. At 1643 hours, the medication cart was found unlocked in the hallway by the medication room with one PSW and several residents in the proximity to the cart. The LTC Homes Inspector was able to open drawers on the cart and access medication with no registered staff present. Registered staff #145 returned to the cart after being in the staff washroom for an unidentified period of time, reported only they were to have access to the cart and confirmed it was left unlocked. Registered staff #145 reported it was inconvenient to lock the cart each time they left it when conducting the medication pass. [s. 129. (1) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they were not being supervised by staff.

A. During an initial tour of the home, the staff washroom on home area four was noted to be unlocked and unsupervised by staff. Upon further inspection, the room did not include access to the resident-staff communication and response system. Interview with PSW #112 confirmed that the staff washroom was a non-residential area and was to be kept closed and locked when not in use.

B. On May 5, 2016, during an initial tour of the home, a staff washroom on home area two was found unlocked and unsupervised, as confirmed by registered staff #107. On May 5 and 12, 2016, soiled utility room 103 was found unlocked and unsupervised, as confirmed by PSW #110.

The previous Administrator confirmed the doors lead to non-residential areas and were to be locked when unsupervised. (585) [s. 9. (1) 2.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

During the inspection, a resident-staff communication and response system was not observed in the outdoor courtyard adjacent to the home area one activity room and home area two dining room. Administrator #001 confirmed the area was used by residents and did not contain a resident-staff communication and response system. [s. 17. (1) (e)]

WN #12: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Continence Care and Bowel Management Program included an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff.

Review of the home's Continence Care and Bowel Management Program and the resident and family satisfaction survey did not include an evaluation of the continence care products by either residents or families. Interview with Staff Educator #002 and the DOC confirmed that in 2015 /2016 an annual resident satisfaction evaluation of continence care products in consultation with residents and substitute decision-makers had not been completed. [s. 51. (1) 5.]

WN #13: 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 failed to ensure that planned menu items were offered at each snack.

On May 5, 2016, during an observation of the afternoon nourishment pass, resident #024 was not offered a snack as per the planned menu. Interview with PSW #138 reported the resident required pureed texture and they did not have puree snack available. The Nutrition Manager located the puree snack on the cart and confirmed the resident was not offered a snack as per the planned menu. [s. 71. (4)]

WN #14: 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. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provided direct care to residents received training annually in accordance with O. Reg 79/10, s. 221 (1) 1 in the area of falls prevention and management.

Information provided by the home indicated 79 percent of direct care staff received training in falls prevention and management in 2015 and this was confirmed by the DOC. [s. 76. (7) 6.]

WN #15: 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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

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

A. Review of the home's Resident Council Minutes from 2015 and 2016, did not include any documentation to support that the licensee sought out the advice of the council in developing and carrying out the satisfaction survey. Interview with the Resident Council Assistant confirmed that the home used the "Abaqis" questionaire and did not ask the advice of the council in carrying out the survey.

B. Review of the Family Council minutes from April 2016, to April 2015 and interview with a family council member revealed that the Family Council did not have input into the survey and this was confirmed by the Resident and Family Coordinator. [s. 85. (3)]

2. The licensee failed to document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Review of the Family Council minutes from 2015 and 2016, interview with a Family Council member and with the Resident and Family Coordinator confirmed that the satisfaction survey results in 2015 were not documented or made available to the council. [s. 85. (4) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for, cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices for supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

The home's procedure, Cleaning Procedure for Nursing Care Equipment, effective May 2007, stated resident wheelchairs were to be cleaned weekly by night staff, wash thoroughly with disinfectant solution, use a brush to remove dried on particles and dry thoroughly.

i. On May 5, 10 and 12, 2016, resident #008's tilted wheelchair frame was observed covered in dried fluid and dried debris. Review of the PSW weekly cleaning schedule revealed the wheelchair was scheduled for cleaning on May 8, 2016 and documentation revealed it was not cleaned during the night shift. On May 12, 2016, PSW #104 and PSW #105 reported wheelchairs were to be cleaned on a weekly basis and confirmed the wheelchair was visibly unclean.

ii. On May 11 and 12, 2016, resident #011's electric wheelchair was observed covered in dry debris on the frame as well as dry fluid debris. Review of the home's weekly cleaning schedule documented that the chair was cleaned on May 11, 2016 on night shift; however, on May 12, 2016, on day shift registered staff #107 confirmed the chair was still visibly unclean.

Interview with registered staff #106 confirmed the home's procedure for cleaning resident equipment included weekly cleaning of wheelchairs. [s. 87. (2) (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

On May 5, 2016, at approximately 1000 hours and on May 12, 2016, at approximately 1320 hours and 1340 hours, soiled utility room #130 was found unlocked and unsupervised. PSW #110 reported the room contained cleaning supplies and chemicals that were potentially hazardous to residents and was to be locked at all times. Administrator #002 confirmed the door was to remain locked. [s. 91.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee failed to ensure when they received a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act, a copy of the complaint was submitted to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

In March 2016, a CIS report was submitted to the MOHLTC regarding allegations of staff to resident abuse. Review of the home's investigation notes revealed the home became aware of the allegations through a written e-mail complaint; however, a copy of the complaint was not submitted with the CIS report as confirmed by the DOC. [s. 103. (1)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was created and maintained for each resident of the home.

A. In March 2016, resident #004 was coded in a MDS assessment as experiencing urinary incontinence as well as having an increase in their care needs for toileting and dressing. The MDS coding triggered mandatory RAPS to be completed; however, review of the RAPS for ADLs and urinary continence did not include a description of the resident's problem/need, nature of their problem/condition, whether the problem/condition would be addressed in their care plan and the impact of their problem/need on the resident as well as a rationale for care plan decision.

Furthermore, in March 2016, the MDS Assessments for residents #048, triggering six RAPS and resident #049 triggering five RAPS, did not include completed RAPS.

Interview with Staff Educator #002 reported the RAPS were completed; however due to technical difficulties, the completed RAPS went missing from the assessment when submitted to the Canadian Institute for Health Information (CIHI). It was also confirmed that the issues affected a total of 14 residents' MDS Assessments from March 2016. The home failed to ensure that the written record was maintained for resident #004, resident #048 and resident #049.

B. Resident #010 sustained unwitnessed fall on an identified day in January 2016 and progress notes indicated that HIR was initiated. Review of the plan of care did not provide documentation of the HIR completed. Interview with registered staff #145 confirmed that they documented the HIR post fall in the paper chart; however, was not able to locate the completed HIR record. [s. 231. (a)]

Issued on this 10th day of June, 2016

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

Original report signed by the inspector.