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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 18, 2018	2018_680687_0016	010478-18	Resident Quality Inspection

Licensee/Titulaire de permis

Board of Management for the District of Nipissing West
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

Au Chateau
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

LOVIRIZA CALUZA (687), AMY GEAUVREAU (642), JENNIFER BROWN (647), SYLVIE BYRNES (627), TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 11-15 and June 18-22, 2018

Additional logs inspected during this Resident Quality Inspection (RQI) included:

Four intakes related to the Infection Prevention and Control Program.

Six intakes related to Abuse.

Two intakes related to Falls.

One intake related to Neglect.

A follow up intake from inspection #2018_669642_0007; related to compliance order #001, regarding s. 8 (3) of the LTCH, 2007, specific to ensuring that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Environmental Manager, Dietary Supervisor, Registered Dietitian (RD), Wound Care/Continence Care Lead, Infection Prevention and Control (IPAC) Lead, Coordinator of Resident Services, Account Receivable Staff, Administrative Assistant (AA), Resident Assessment Instrument (RAI) Coordinator, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), health care aids (HCAs), dietary aids (DAs), housekeepers, activity workers, agency staff, family members and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **7 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. 8. (3)	CO #001	2018_669642_0007	627

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's furnishings and equipment were maintained in a safe condition.

a) During three separate tours of the home, Inspector #647 observed that the towel bar holders in certain resident's room were loose.

Inspector #647 observed on three separate occasions that the residents call bell had not been functioning when activated for resident #003 and #008.

Registered practical nurse (RPN) #124 and personal support worker (PSW) #103 had been in the presence of Inspector #647 at the time of the above mentioned observations and acknowledged that the towel bar holders in the identified washroom were loose and could potentially fall out of the wall. In addition, the call bells for residents' #003 and #008 had not been functioning after four attempts.

During an interview with Inspector #647, PSW #103, #109, and registered nurse (RN) #108, indicated that there was a maintenance program in place for reporting any required repairs. They further indicated that the above mentioned items would have been required to be reported to environmental services.

Inspector #647 completed a record review of the maintenance requisitions on the specified dates, and found that there was no requisition initiated for the above indicated loose towel bar holders or malfunctioning call bells.

During an interview with Inspector #647, the Environmental Manager indicated that there were many ways for staff to request a repair which included calling, texting, emailing, or

completing a paper requisition. The Environmental Manager further indicated that they had not been informed of the loose towel bar holders or malfunctioning call bells as indicated above and therefore the equipment had not been maintained in a safe condition.

b) During a tour of the home on the particular day, Inspector #627 identified a bath tub in disrepair. It was observed that the outside edge of the tub had sticky black residue and no bumper pad.

On a particular day, Inspector #647 identified during an observation that a sit to stand lift on the floor was in disrepair. It was identified that the arm and foot rest foam of the sit to stand lift was moderately damaged and exposed.

During an interview with Inspector #687, PSW #137 stated that the sit to stand lift on the floor was in disrepair as the foam from the arm and the foot rest of the lift was moderately damaged and exposed. However, the staff has no other alternative to use.

During an interview with Inspector #687, housekeeper #158 stated that the tub bath was in disrepair on the floor. The housekeeper stated that the black bumper pad along the outside edges of the tub was off and left an inch of brownish-black foam residue. The housekeeper could not verify a specific time frame of when this happened. [s. 15. (2) (c)]

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 furnishings and equipment are maintained in a safe condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

Ontario Regulation (O. Reg.) 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

During an interview with resident #010, they reported to Inspector #627 that on a particular day, their roommate, resident #011, had been left on a specified device for a period of time. The resident stated that the staff usually told them to call when resident #011 was done using the device, however on this particular shift, the staff had not made them aware that resident #011 was on the device. Resident #010 stated that they had woken up when resident #011 was fidgeting and had called the staff who noticed that the resident remained on the device.

Inspector #627 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect", last reviewed January 18, 2018, which identified "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. The home's policy also identified that the home was committed to zero tolerance of abuse and neglect of its resident.

Inspector #627 reviewed resident #011's care plan in effect at the time of the incident which indicated specified interventions related to the device.

Inspector #627 reviewed the "resident's flow sheet", where the specified intervention was to be documented and found no entry for the specified dates.

Inspector #627 interviewed PSW #112 who stated that resident #001 was offered the specified device along with specified interventions. The staff advised their roommate, resident #010, to call staff at a certain time if resident #011 was unable to call. The PSW further stated that resident #011 had been left on the specific device "a couple of times", when staff had forgotten to return and provide assistance.

Inspector #627 interviewed PSW #148 who stated during a particular day, they had worked with PSW #149 and PSW #150. PSW #148 stated that they had placed resident #011 on the specified device at a certain time and had informed PSW #149 and had left for their break. PSW #148 indicated that they had not thought of "checking" resident #011 when they returned from their break. PSW #148 further stated that when they had entered the room to provide care to resident #010, resident #011 was receiving a treatment and had not mentioned that they remained on the device. PSW #148 acknowledged that they had not provided the specified intervention to resident #011 after placing them on the specified device. PSW # 148 further stated that they had received a call from the DOC at a certain date, at which time they were made aware of the incident and that it constituted neglect of resident #011.

Inspector #627 interviewed PSW #150 who stated that they had worked on the particular day, along with PSW #148 and PSW #149. They stated that they had been "buddied" with PSW #149. PSW #149 informed the Inspector that they had not provided the specified intervention to resident #011 during the specified time while using the device.

Inspector #627 interviewed RN #152 who stated that PSW #142 and RPN #151 had made them aware of the incident during a specific round on the floor. They further stated that resident #011 had a specified intervention and had staff followed the intervention, it would have been noted that resident #011 remained on the specified device.

During an interview with the Director of Care (DOC), Inspector #627 revealed to the DOC that PSW #148 had stated that they had placed resident #011 on the device at the specified time prior to their break. The resident had remained on the specified device until a certain time when resident #010 had rang for the staff to make them aware that resident #011 required assistance. The DOC acknowledged that the resident's specified intervention was not followed as scheduled or staff would have noticed that resident #011 remained on the device. The DOC further acknowledged that on that particular shift, many staff members were moved around units which caused confusion as to who was assigned to what unit. For this reason, resident #011 had not received the care they required. [s. 20. (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 home's written policy to promote zero tolerance of abuse and neglect of residents, is complied with, to be implemented voluntarily.

WN #3: 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 a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which is it based to the Director: 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.

During an interview with Inspector #627, resident #010 alleged that resident #011 was neglected by staff on a particular date. Please see WN #2 for details.

Inspector #627 reviewed the progress notes for resident #011 on the specified date which indicated that RN #108 had received a call from resident #011's family member with concerns that resident #011 was left on the specified device for an identified period. RN #108 had informed the family member that they would investigate the incident.

Inspector #627 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect", last reviewed January 18, 2018, which indicated that, "all staff to fulfill their legal obligation and to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the Ministry of Health and Long Term Care (MOHLTC)". As designate of the home, they were responsible for completing reports using the Critical Incident System to the MOHLTC. The designate may initiate the MOHTLC report together with the person who witnessed the incident of abuse or neglect.

On a particular day, Inspector #627 searched the MOHLTC online reporting site and was unable to locate a critical incident (CI) report for this incident.

Inspector #627 conducted an interview with PSW #142 who stated that they had worked the specified dates. The PSW stated that they became aware that resident #011 remained on the specified device for the identified period and when resident #010 had called for staff. They stated that they had reported the incident to RPN #151 and together, they had reported it to RN #152 during the shift.

Inspector #627 interviewed RN #152 who stated that PSW #142 and RPN #151 had made them aware of the incident during a specific round on the floor. The RN further stated that they were going to email the DOC regarding the incident but that they had forgotten. The RN acknowledged that resident #011 had not been provided with the care they needed and as the RN in-charge, they should have called the after-hour ministry line and informed the DOC and the Administrator of the incident.

Inspector #627 interviewed RN #108 who stated that they had been made aware of the incident from resident #010 from a telephone call they had received from resident #011's family member. They had informed the family member that they would investigate the incident. RN #108 stated that they had not reported the incident to the MOHLTC as they had not recognized it as neglect since it was unintentional. The RN acknowledged that in this incident not providing the care required to a resident constituted neglect.

Inspector #627 interviewed the DOC who stated that they had been made aware of the

incident by RN #108, however they had not reported it as this had been unintentional. The DOC further stated that neglect was defined as not providing the care required to a resident, and that resident #011 had not been provided with the care they required. The DOC stated that they would report the incident immediately and further stated that when an incident of neglect, or suspicion of neglect was reported, the Charge RN was to report the incident to the after hour ministry line. [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 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 is it based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident (CI) report was submitted to the Director which outlined how on a particular date resident #015 had been transferred by PSW #155 using a specified device without the presence of a second staff member. The CI report further indicated that resident #015 slipped from the device which resulted in an injury and was transferred to hospital.

In a record review of the home's internal investigation notes by Inspector #690, it was identified that PSW #155 had transferred resident #015 with a specified device on their own.

Inspector #690 reviewed the most current care plan which indicated that resident #015 had a medical diagnosis which required a device for transfers.

Inspector #690 reviewed the progress notes which indicated that resident #015 was being transferred with the specified device and the resident fell to the floor and sustained an injury and was transferred to hospital for further assessment.

In an interview with Inspector #690, PSW #137 indicated that it was the home’s policy that all transfers using the device were to have two staff present.

In an interview with Inspector #690, RN #159 indicated that PSW #155 had transferred resident #015 with the specified device by themselves and that resident #015 fell from the device and sustained an injury. RN #159 indicated that it is the home’s policy to have two staff present for all transfers with the specified device.

In an interview with Inspector #690, the DOC indicated that PSW #155 had transferred resident #015 without the presence of a second staff member and acknowledged that the resident had not been transferred safely. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: 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 were offered and available at each meal and snack.

Inspector #647 reviewed the weekly menu posted on the specified home area which indicated that the following items were available: peach pineapple juice, caesar salad, spaghetti, whole wheat roll and maple cake or, peameal bacon, mashed potatoes, beets, apple slices or apple sauce.

Inspector #647 completed a dining room observation at meal time on the particular date, which revealed that the peach pineapple juice, whole wheat roll and apple slices were not offered to residents as posted on the menu. These items and were not replaced by another food item.

Inspector #647 reviewed the another weekly menu posted on the specified home area which indicated the following items were available: apple juice, roast turkey, cranberries, mashed potatoes, corn, carrot cake or, salmon, rice, brussel sprouts, and diced cantaloupe.

An observation by Inspector #647 at meal time on the particular date, revealed that the diced cantaloupe was not offered to residents as posted in the menu. This item and was not replaced by another food item.

Inspector #647 interviewed the dietary supervisor who indicated that they were not aware that these items were not served to the residents on the specified home area and further confirmed that the above mentioned planned menu items were not offered to the residents. [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 and available at each meal and snack, to be implemented voluntarily.

WN #6: 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: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortable and independently as possible.

During a meal observation conducted by Inspector #647 on a specified home area, the Inspector observed on a particular date that:

-Resident #001 had received a specific eating device with their meal.

During another meal observation on the specified home area, Inspector #647 observed that:

-Resident #001 had received a specific eating device with their meal.

-Resident #024 had received an eating device with their meal.

Inspector #647 conducted a record review of a document titled "resident meal choice" and "seating plan" which indicated that:

-Resident #001 was not to have received a specified eating device with meals.

-Resident #024 required a specific eating device with their meal (different than what had been observed).

During separate dining room observations conducted by Inspector #647, PSW #103 and RPN #114 confirmed that resident #001, #002, and #024, were all provided incorrect eating aids or assistive devices to encourage them to safely eat, drink, and be as independently as possible.

During an interview with Inspector #647, the Dietary Supervisor indicated that the resident meal choice form and seating plan were kept current with all resident's needs. The Dietary Supervisor further indicated that staff are required to follow the meal choice form and seating plan to ensure all residents received the correct eating aids or assistive devices to encourage them to safely eat, drink, and be as independently as possible. [s. 73. (1) 9.]

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 provided with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortable and independently as possible, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the program.

a) Inspector #687 reviewed the home's policy titled, "Hand Hygiene Program" date issued December 2006, which indicated that the staff must washed their hands:
- before and after contact with residents and/or their environment
- before preparing, handling, serving food or feeding a resident

During an observation in a particular day, Inspector #687 observed housekeeper #110 not performing hand hygiene before and after resident interactions and after picking up dirty dishes in a specified dining room.

In a separate observation in the specified dining room, Inspector #687 observed PSW #123 picking up a used tissue paper on the floor and was observed immediately serving

the resident their meal. PSW #123 was not observed performing hand hygiene prior to a resident interaction.

During an interview with Inspector #687, PSW #144 stated that the staff were required to complete hand hygiene before and after resident encounters. PSW #144 further stated that the staff were required to complete hand hygiene after picking up dirty dishes in the dining room.

b) Inspector #687 reviewed the home's policy titled " Hand Hygiene Program" date issued December 2006, which indicated that the direct observation of hand hygiene practices were completed by trained observers using a standardized audit tool.

In an interview with the Infection Prevention and Control (IPAC) lead, the Inspector requested the hand hygiene practices audits and the IPAC lead stated that the Resident Assessment Instrument (RAI) Coordinator was the staff who kept the records of the hand hygiene practices audits.

In an interview with the RAI Coordinator, they stated that they had no record of the hand hygiene practices audits.

In a separate interview with the IPAC lead, they stated that they were under the impression that the RAI Coordinator kept the record of the hand hygiene practices audits and later acknowledged that they have no record of it. [s. 229. (4)]

2. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During a record review of the home's respiratory line listing for a period of twelve days, Inspector #687 identified that resident #029, #030 and #031 were included in the home's respiratory surveillance record.

a) Inspector #687 reviewed resident #029's progress notes, which indicated that the resident had been placed on isolation precautions for a suspected infection on a particular date.

The Inspector reviewed resident #029's health care records, specifically the documentation records regarding their symptoms of infection. The Inspector was unable

to identify any record of the resident's symptoms of infection for a specific shift on seven of the identified dates. In addition, the Inspector was unable to identify any record of the resident's symptoms of infection for the a different shift on seven of the identified dates.

b) Inspector #687 reviewed resident #030's progress notes, which indicated that the resident had been placed on isolation precautions for a suspected infection on a particular date.

The Inspector reviewed resident #030's health care records, specifically the documentation records regarding their symptoms of infection. The Inspector was unable to identify any record of the resident's symptoms of infection for the specific shift on six of the identified dates. In addition, the Inspector was unable to identify any record of the resident's symptoms of infection for a different shift on five of the identified dates.

c) Inspector #687 reviewed resident #031's progress notes, which indicated that the resident had been placed on isolation precautions for a suspected infection on a particular date. The resident was maintained on isolation precautions until one week later.

The Inspector reviewed resident #031's health care records, specifically the documentation records regarding their symptoms of infection. The Inspector was unable to identify any record of the resident's symptoms of infection for the specified shift on four of the identified dates. In addition, the Inspector was unable to identify any record of the resident's symptoms of infection for a different shift on three of the identified dates.

Inspector #627 reviewed the home's policy titled "Infection Prevention and Control Program", last reviewed in 2017, which indicated that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidenced-based practice and, if there were none, in accordance with prevailing practices; and that the symptoms were recorded and that immediate action was taken as required.

In an interview with Inspector #687, RN #140 stated that a resident was placed on isolation precautions when they displayed two or more symptoms of a respiratory infection. The RN stated that once isolated the resident's symptoms of infection were monitored and recorded during each shift.

In an interview with Inspector #687, the IPAC Lead stated that whenever a resident was isolated, the resident should be monitored and their symptoms recorded on each shift

while on isolation precautions. [s. 229. (5) (b)]

3. Resident #010 was identified as having had an infection from their most recent MDS assessment.

Inspector #627 reviewed resident #010's electronic progress notes which identified that on a particular day the resident had been showing signs of infection symptoms and were under specified isolation precautions but failed to identify the duration of the isolation. The Inspector was able to identify in the progress notes on three identified dates regarding infection symptoms.

Inspector #627 interviewed the IPAC lead who verified that the unit had an infection outbreak during this period and resident #010 was placed on a specified isolation precaution on a particular date. The IPAC lead determined that the resident was on specified isolation precautions for six days, however they were unable to determine when the resident had been removed from isolation.

Inspector #627 interviewed PSW #113 who stated that resident #010 was on infection isolation during the specified month, however, they were unable to recall the exact dates. They further stated that when a resident was on isolation precautions, the PSWs would report the resident's symptoms to the registered staff.

Inspector #627 interviewed RN #120 and #126 who stated that when a resident presented with symptoms of infection, the RN was called by the RPN to assess the resident. The resident's symptoms were assessed on every shift, by the RPN or the RN and were documented in the home's electronic health record. A scheduled event was created in electronic health record to ensure an assessment was conducted.

Inspector #627 and RN #120 reviewed resident #010's electronic health record. RN #120 acknowledged that there was no scheduled event and that the resident's symptoms and vitals were not monitored and documented on every shift. RN #120 further acknowledged that they could not identify when the specified isolation precautions were removed.

Inspector #627 interviewed the DOC who verified that when a resident displayed symptoms of infection, they were to be assessed on every shift; this included subjective and objective symptoms such as the specified assessments. The DOC acknowledged that this had not occurred when resident #010 was placed on isolation precautions for a specified infection. [s. 229. (5) (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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #8: 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. (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 has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Resident #017 was identified as having had a fall from their past to most recent minimum

data set (MDS) assessment.

Inspector #690 reviewed resident #017's plan of care on a particular date, which revealed that the resident required a specific intervention to be applied at all times.

Inspector #690 reviewed the progress notes, which revealed that resident #017's enacted substitute decision maker (SDM) was in agreement with trialing the intervention only at a specified time and that staff were aware of the changes and would apply the intervention and update the bedside board.

On a particular date, Inspector #690 observed resident #017 in their bedroom. The Inspector observed the bedside board which indicated that the resident was to have a specific intervention in place only at the time specified by the SDM.

During various observations by Inspector #690 of resident #017, the resident did not have the specified intervention in place, which was contrary to what was identified in the plan of care.

In an interview with Inspector #690, PSW #137 identified that resident #017 had an intervention in place during the specified time as identified by the SDM.

In an interview with Inspector #690, RPN #135 identified that resident #017 only used the specified intervention at a certain time (as specified by the SDM). RPN #135 identified that the current written plan of care indicated that resident #017 was to use the intervention at all times. RPN #135 identified that the written plan of care had not provided clear direction.

In an interview with Inspector #690, the Director of Care (DOC) identified that the written plan of care indicated that resident #017 was to use the specified intervention at all times which had not provided clear direction to staff. [s. 6. (1) (c)]

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

On a particular day, Inspector #627 observed resident #012 sitting in a wheelchair.

On another particular day, Inspector #627 observed resident #012 in their room, in their wheelchair tilted at a specified degree, partway between the bathroom and the bed.

Inspector #627 reviewed the care plan in effect at the time of the inspection which indicated that for the focus of activity of daily living potential for skin breakdown and activation, a specified intervention was in place for resident #012.

Inspector #627 reviewed the home's policy titled "Resident Care Plan", last reviewed June 2018, which indicated that "the resident's care plan was a set of directives determined to provide the care each resident needed".

Inspector #627 interviewed PSW #123 who stated that on the specified date, resident #012's specified interventions as stated in the care plan were not followed.

Inspector #627 interviewed the DOC who indicated that resident #012's specified interventions in the care plan had not been followed. [s. 6. (7)]

3. On a particular day, Inspector #627 observed resident #005 sleeping in bed in their bedroom.

In subsequent dates, Inspector #687 observed resident #005 either sleeping in their bed or sleeping in their wheelchair.

Inspector #687 reviewed the resident's most current care plan which indicated that the staff should offer daily activities suitable to resident #005's cognitive level and listed a selection of activities.

During an interview with Inspector #687, PSW #109 indicated that they had not seen any activity workers engaging resident #005 to participate in any identified activities.

During an interview with Inspector #687, RPN #134 indicated that currently there were no identified activities on the floor.

In an interview with activity worker #153, they indicated that there was no record for any identified activities with resident #005 since January 2018.

In an interview with the Coordinator of Resident Services, they indicated resident #005 was not getting any activities which they were supposed to as specified in the resident's care plan. [s. 6. (7)]

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

Resident #012 was identified as having poor expression or understanding, no or inadequate administration of therapy and no modes of expression to make needs known according to the most recent full MDS assessment.

During an observation, Inspector #627 observed resident #012 in their room, reclined in their wheelchair. The call bell was observed under the resident's bed, out of reach of the resident.

Inspector #627 reviewed resident #012's care plan in effect at the time of the inspection, for the focus of safety which indicated that the call bell was to be within reach and for the staff to provide cueing as to the call bell location.

Inspector #627 reviewed the home's policy titled "Resident Care Plan", last revision date June 2018, which indicated that the care plan must be revised as frequently as necessary depending upon the resident's changing needs.

During separate interviews with PSW #127 and PSW #128, they indicated to the Inspector that the resident was no longer capable of using the call bell.

Inspector #627 interviewed registered nurse (RN) #126 who stated that the resident was no longer able to use the call bell due to their medical condition. The RN further stated that the intervention for resident #012 should be removed and that the resident should have been monitored more frequently.

Inspector #627 interviewed the resident assessment instrument (RAI) Coordinator who stated that they would update resident #012's care plan as the resident no longer used the call bell and would be monitored more frequently. [s. 6. (10) (b)]

5. Resident #010 was identified as being incontinent from the previous to most recent MDS assessment.

Inspector #627 reviewed resident #010's care plan in effect at the time of the inspection which indicated that, for the focus of continence, the resident had a specified level of continence and used a specified intervention.

Inspector #627 interviewed resident #010 who stated that they used a specific intervention at certain times only. They stated that they went to the bathroom independently and would ring for assistance if required.

Inspector #627 interviewed PSW #112 who stated that resident #010 toileted independently and called for assistance if required. The PSW further stated that the resident only used an specified intervention at a certain time.

Inspector #627 interviewed RPN #125, who was the lead for the Continence program and indicated that resident #010 only used a continence intervention at a certain time. In the past, resident #010 had used a different continence intervention but no longer used these interventions. RPN #125 acknowledged that resident #010's care plan had not been updated when the resident's care needs had changed. [s. 6. (10) (b)]

6. Resident #006 was identified as having altered skin integrity from their previous to most recent MDS assessment.

Inspector #647 reviewed the MDS assessment, which indicated that the resident had two areas of altered skin integrity.

Inspector #647 reviewed the written plan of care for resident #006, which indicated a focus, "skin integrity/pressure ulcer or risk of pressure ulcer" and further indicated a specific intervention.

During separate interviews with Inspector #647, PSW #107 and RPN #134 indicated that the resident previously had two areas of altered skin integrity, however they were now healed.

In multiple observations by Inspector #647 of resident #006, there were no areas of altered skin integrity and the specific intervention had not been used.

Inspector #647 interviewed RN #120, who indicated that one of the duties of the RNs in the home was to ensure that the written plans of care were reviewed and revised at a minimum quarterly, and further reviewed and revised with any changes of health status. RN #120 verified at the time of the interview that the written plan of care indicated that the resident currently had two areas of altered skin integrity and required a specific intervention. However, the RN further verified that resident #006's two areas of altered

skin integrity had since healed and no longer required an intervention. [s. 6. (10) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had their personal items labelled within 48 hours of admission and of acquiring new items.

During a tour, Inspector #687 observed in resident #028's shared bathroom, multiple unlabelled personal items.

Inspector #627 observed multiple used personal unlabelled items in a specified tub room. PSW #103 accompanied Inspector #627 to observe these personal items, who then stated that resident personal items were supposed to be labelled and kept in the residents' room.

Inspector #627 also identified multiple used personal unlabelled items in another specified tub room. PSW #103 accompanied Inspector #627 to observed these personal items, who then stated that resident personal items were supposed to be labelled and kept in the residents' room.

Inspector #627 interviewed housekeeping staff #139 who stated that they threw out personal items left in the tub rooms as the items were never labelled which made it impossible to identify who it belonged to. These items were to be stored in a sewed bag, however the bags were unlabelled and many of the bags had gone missing.

During an interview with Inspector #627, the DOC indicated that the residents' personal items on a specified unit were stored in a basket or sewed bag in the resident's locked cupboard. The DOC stated that they were not sure if the baskets or bags were labelled. The DOC further indicated that the residents' items should be labelled and put away in residents room after use. The DOC acknowledged that this was an ongoing issue and that the labeling of residents' personal items was not always done. [s. 37. (1) (a)]

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

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

Inspector #687 reviewed the home's policy titled, "Operational Procedures - Equipment" revised May 2009, which indicated that "the maintenance department personnel were to check all equipment in the building to ensure maximum serviceability". "All equipment, especially those used in the care of residents must be kept in good condition and checked before use".

In an interview with the Inspector #687, the Environmental Manager stated that there was no set schedule for maintenance checks on the floor lifts or sit to stand lifts. The maintenance department relied on staff to report to them any maintenance concern and their supplier came yearly to check the equipment. The Environmental Manager further stated that they had noticed the disrepair of the sit to stand lift on a specified floor approximately six weeks ago and requested for a replacement of the equipment from their supplier four weeks ago. The Environmental Manager stated that they were not aware of the disrepair of the bath tub on a specified floor but would act upon it to have the tub bath fixed and have the black bumper pad installed immediately. Please see WN #1 for details. [s. 90. (2) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or an earlier date if required by the Director.

Inspector #642 , reviewed a CI report submitted to the Director which alleged abuse from resident #022 towards resident #021. The alleged incident had initially been reported to the after hours MOHLTC hotline on a particular date.

Inspector #642 reviewed the CI report and noted that the report had not been submitted to the Director by the long-term care (LTC) home until almost one month later.

Inspector #627 interviewed the DOC, who stated the CI report was submitted late as the RN failed to print the report for management to initiate the online critical incident system (CIS). The DOC became aware that a CIS was submitted when the MOHLTC called to remind them to complete the CIS. The DOC completed the CIS on the specified date. [s. 104. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was reported to the resident's substitute decision maker (SDM).

Inspector #627 reviewed a medication incident report, which indicated that resident #025 had not received their prescribed medication at a specified time frame and no harm had come to the resident. The incident report identified that RN #108 had completed the follow up and it was documented that the SDM had not been notified as no harm had come to the resident.

Inspector #627 reviewed the home's policy titled "Medication Incidents", last updated 2017, which indicated that the nurse supervisor was to call the physician, pharmacist and SDM when a medication incident occurred

During an interview with Inspector #627, RN #108 informed the Inspector that they had been the nurse supervisor at the time of the incident. RN #108 indicated that the nurse manager was responsible for notifying the physician, the pharmacist and the resident's SDM. The RN further stated that they had not called resident #025's SDM when the incident occurred as no harm had come to the resident.

Inspector #627 interviewed the DOC who stated that it was the home's policy that the resident's SDM be notified of any medication incident even when the resident sustained no ill effect from the incident. [s. 135. (1)]

Issued on this 2nd day of August, 2018

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

Original report signed by the inspector.