Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 12, 2015	2014_340566_0023	T-002-14	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

AURORA RESTHAVEN
32 MILL STREET AURORA ON L4G 2R9

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

ARIEL JONES (566), NITAL SHETH (500), SUSAN LUI (178)

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): December 30, 31, 2014, January 2, 5, 6, 7, 8, 2015.

The following complaint intake was inspected: T-475-14.
The following critical incident intake was inspected: T-569-14.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), director of social services, registered dietitian (RD), physiotherapist, occupational therapist, food services manager (FSM), programs and services manager, environmental services supervisor (ESS), education coordinator, registered staff members, personal support workers (PSW), physiotherapy assistant, activation aides, housekeepers, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
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
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted.

An interview with resident #11 revealed that PSW #1 was repeatedly rough with him/her when assisting with showers. The resident stated that due to his/her identified diagnosis, he/she experiences a lot of pain with movement. On an identified date in December 2014, in the evening, PSW #1 provided a shower to the resident. Further interviews with resident #11 revealed that PSW #1 pulled the resident's arm during the shower, and the resident stated: "please stop, it is painful". The PSW reportedly did not stop. The resident reported to the inspector that on many occasions PSW #1 made comments about the resident's weight and called him/her "fat". The resident indicated further that he/she had reported the incident to the charge nurse on the floor, but that nothing had been done and PSW #1 continued to provide his/her care. The resident confirmed that he/she felt as if PSW #1 should be more respectful toward him/her.

A review of the resident's plan of care and staff interviews confirmed that the resident is cognitively well.

An interview with PSW #2 confirmed that the resident had complained that PSW #1 had been rushed/rough with him/her.
An interview with the evening charge nurse on the floor confirmed that the resident complained to him/her about PSW #1 calling him/her "fat".

An interview with the DOC confirmed that subsequent to the inspector's interviews with staff, the home initiated an investigation into the allegations. The DOC confirmed that PSW #1 will not be providing care to resident #11 and has been moved to another floor where the residents are largely cognitively well and able to advocate for themselves. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Record review and staff interviews confirmed that the plan of care for resident #08 with regards to the treatment of an identified ulcer, did not set out clear directions to staff.

Record review and staff interviews confirmed the following:
Resident #08 was assessed by a wound consultant, and recommendations were made for dressing treatments of the resident's ulcers. These recommendations were transcribed onto the physician's order sheet, signed by the physician, and transcribed by the nurse into the resident's Treatment Administration Record (TAR). One of the identified directions was omitted when the treatment order was transcribed onto the resident's TAR. As a result, this step was not carried out by the nurse who changed the resident's dressing.

An interview with the DOC confirmed that he/she had been made aware of the error and he/she instructed the nurse involved to complete a medication error incident report. [s. 6. (1) (c)]

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

A review of resident #25's plan of care revealed that the resident fell on an identified date and time in March 2014 in the Mill Unit basement dining room. A review of the interventions from an identified date in February 2014, indicated that staff were to provide extensive assistance with walking and locomotion and to provide directions as the resident's diagnosis includes an identified visual impairment.

A review of the home's investigation records around the resident's fall incident indicated that the resident was found on the floor close to an identified table in the dining room. A review of a seating plan of the dining room revealed that the resident's seat was at another identified table. The home's staff interview notes from their investigation confirmed that there were not any staff members present in the dining room at the time of fall.

An interview with the DOC confirmed that the resident did not receive assistance from the staff, as specified in his/her plan of care. This resulted in a fall, an identified injury and hospitalization with surgery. [s. 6. (7)]

3. A review of resident #11's plan of care for bathing revealed that the resident requires the use of a sit-to-stand lift with two staff to transfer him/her on and off the shower chair.

An interview with PSW #1 revealed that he/she does not always use the sit-to-stand lift for the resident's transfer to/from the shower chair.

Resident interview confirmed that the staff do not always use a mechanical lift to transfer him/her onto the shower chair. The resident reported further that sometimes only one staff member assists him/her to transfer manually to the shower chair by holding onto the grab bars for support, and that this causes the resident pain.
An interview with a member of the registered nursing staff confirmed that the resident sometimes refuses to be transferred using a mechanical lift, however, the staff has not documented this.

An interview with the DOC confirmed that transferring care should be provided as per the resident's plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

A review of resident #25's plan of care revealed that the resident fell on an identified date and time in March 2014 in the Mill Unit basement dining room. A review of the interventions from an identified date in February 2014, indicated that staff were to provide extensive assistance with walking and locomotion and to provide directions as the resident's diagnosis includes an identified visual impairment.

A review of the home's investigation records regarding the resident's fall indicated that the two PSWs who provided care to the resident were not aware that the resident had an identified visual impairment and required assistance with walking and locomotion.

An interview with the DOC confirmed that both the PSWs involved in the resident's care at the time of the incident were not aware that the resident had an identified visual impairment and required assistance with mobility. This resulted in a fall, an identified injury and hospitalization with surgery. [s. 6. (8)]

5. The licensee failed to ensure that different approaches are considered in the revision of the plan of care because care set out in the plan has not been effective.

A review of the plan of care for resident #11 revealed that the resident was at high risk for falls and sustained a fall on an identified date and time in December 2014, while the resident was trying to reach for chocolates in his/her room. The plan of care did not indicate that any new interventions were developed after the resident fell to prevent him/her from future falls.

An interview with a member of the registered nursing staff confirmed that it was the second time the resident had fallen while trying to reach something in his/her room. He/She confirmed that there were no different approaches considered or new strategies developed for the resident to prevent him/her from further falls.

An interview with the DOC confirmed that the plan of care should be reviewed and revised when current interventions are not effective. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care, and to ensure that different approaches are considered in the revision of the plan of care because care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: 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 has failed to ensure that all doors leading to non-residential areas are locked when they are not being supervised by the staff.

Observations on December 30, 2014, during the initial home tour revealed that the housekeeping utility rooms on George Unit 1 and 2 were unlocked and unsupervised. These rooms contained four different types of chemical cleaning solutions. Further observations made on January 6, 2014, revealed that the housekeeping utility room on George Unit 2 was unlocked, as well as the equipment supply/mechanical room in the same home area. This room contained a housekeeping cart, various housekeeping supplies, and exposed wiring.

Interviews with both registered staff and housekeeping staff on the units confirmed that the identified areas were unlocked and unsupervised, and should be locked when not in use as these areas contained chemicals and wiring that could pose a risk to residents.

An interview with the DOC confirmed that all non-residential areas should be locked, and that the home would take action to ensure that these doors remained locked when unsupervised, including replacing the locking mechanism if necessary. [s. 9. (1) 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 all doors leading to non-residential areas are locked when they are not being supervised by the staff, to be implemented voluntarily.

WN #4: 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 and its furnishings are kept clean and sanitary.

An interview with resident #13 indicated that the carpet in an identified unit lounge area has never been cleaned.

Observations on January 8, 2015, confirmed the following:
George Unit 1:
- seat of the sofa in lounge was soiled
- carpet stained in lounge area.
George Unit 2:
- sofa in the lounge was soiled with food stains
- feathers and dried leaves were noted on the floor close to the balcony door in the lounge
- carpet stained in lounge area.

At 2:00p.m., observations conducted with the ESS revealed that the toilets in rooms #G1 -7, #G2-6, #G2-7, #G2-12 were stained yellow.

An interview with the ESS confirmed that the above identified sofas and toilets should be deep cleaned, the floor with the feathers and dried leaves should be cleaned by the housekeeping staff, and the identified carpets in both George Unit lounge areas need to be replaced. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home and its furnishings are maintained in a good state of repair.

Observations conducted on December 30, 2014, and on January 8, 2015, revealed that the plastic ceiling tile in Mill elevator #1 was broken in the corner and cracked on the opposite side, and there was damage to the wall and baseboard in the lounge area on Mill Unit 1. Observations conducted on January 8, 2015, in the George Unit 1 lounge revealed that the fabric on the seat of a lounge chair was completely torn.

An interview with the ESS confirmed that the identified ceiling tiles in the elevator and the chair with torn fabric should be replaced, and that the wall damage requires proper repair. [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 and its furnishings are kept clean and sanitary; and to ensure that the home and its furnishings are maintained in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

An interview with resident #08 revealed that he/she feels cold in his/her room.

Temperature readings measured by the ESS in resident #08's room on January 8, 2015, at 2:50p.m., indicated that the recorded temperature readings ranged from 17 to 21.3 degrees Celsius.

An interview with the ESS confirmed that the minimum temperature required in the home is to be maintained at 22 degrees Celsius, and that the recorded temperatures in the resident's room are below the required standard. [s. 21.]

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 is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director under the Long-term Care Homes Act (LTCHA).

An interview with resident #11 revealed that PSW #1 was repeatedly rough with him/her when assisting with showers. The resident stated that due to his/her identified diagnosis, he/she experiences a lot of pain with movement. On an identified date in December 2014, in the evening, PSW #1 provided a shower to the resident. Further interviews with resident #11 revealed that PSW #1 pulled the resident's arm during the shower, and the resident stated: "please stop, it is painful". The PSW reportedly did not stop. The resident reported to the inspector that on many occasions PSW #1 made comments about the resident's weight and called him/her "fat". The resident indicated further that he/she had reported the incident to the charge nurse on the floor, but that nothing had been done and PSW #1 continued to provide him/her care. The resident confirmed that he/she felt as if PSW #1 should be more respectful toward him/her.

An interview with PSW #2 confirmed that the resident had complained that PSW #1 had been rushed/rough with him/her.
An interview with the evening charge nurse on the floor confirmed that the resident complained to him/her about PSW #1 calling him/her "fat".

Neither of these staff members reported the resident's concerns to the Director under the LTCHA. Furthermore, the staff did not report the concerns to the home's management until after they were raised by the inspector.

A review of the Critical Incident (CI) Report #2630-000001-15 revealed that the home first submitted a corresponding CI report on an identified date and time in January 2015.

An interview with the DOC confirmed that the home did not report the above mentioned incident immediately to the Director. [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 improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director under the Long-term Care Homes Act, to be implemented voluntarily.

WN #7: 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 has failed to ensure that the resident exhibiting altered skin integrity, including skin tears, has been assessed by a registered dietitian (RD) who is a member of the staff of the home.

Record review and staff interviews confirmed that resident #06 was not assessed by the home's RD after the resident exhibited skin tears on three different dates in December 2014. The resident also exhibited impaired skin integrity on an identified area of the body in December and was not assessed by the home's RD. The home's RD confirmed that he/she did not receive a referral to assess the resident after these episodes of impaired skin integrity.

Interview with the home's DOC confirmed that any resident with impaired skin integrity should be referred to the RD for assessment. [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 the resident exhibiting altered skin integrity, including skin tears, has been assessed by a registered dietitian who is a member of the staff of the home, 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: 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).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

An observation conducted on December 30, 2014, at 12:00p.m., in the Mill Unit basement dining room revealed that residents #28, #29, #30, and #31 were not provided with the identified eating aids or assistive devices specified in each resident's plan of care.

An interview with the food service manager (FSM) confirmed that the above mentioned residents should receive the identified assistive devices as specified in their plans of care. [s. 73. (1) 9.]

2. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

An observation conducted on December 20, 2014, at 12:00p.m., in the Mill Unit basement dining room revealed that the PSW used a fork to feed resident #26. The same PSW was observed using a tablespoon to feed resident #27.

A review of the home's policy #LTC-CA-WQ-100-09-01, titled Toolkits and Guidebooks, revised September 2014, indicates that when feeding residents a teaspoon is to be used; a soup spoon is not to be used.

An interview with the FSM confirmed that use of table spoon or fork for feeding assistance is not acceptable according to the home's safe feeding technique policy. The PSW should use a teaspoon while feeding the identified residents. [s. 73. (1) 10.]

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 has a dining and snack service that includes, at a minimum, the following elements:
- providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible
- proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #9: 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 has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

On January 5, 2014, at 1:38p.m., resident #02 was observed to be sleeping in his/her bed with the call bell on the floor and inaccessible to the resident.

Interviews with the PSW and registered nursing staff confirmed that the call bell should be always within reach of the resident.

An interview with the DOC confirmed that it is the expectation that call bells should always be within reach of the residents. [s. 17. (1) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including reassessments, are documented.

Record review and staff interviews confirmed that the weekly skin assessments performed on resident #08's wounds were not always documented. Weekly skin assessments were not documented for all of resident #08's wounds on the following dates: November 5, 19, 26, December 3, 10, 17, 30, 2014.

Staff interviews confirmed that the resident's wounds were reassessed at least weekly by a member of the registered nursing staff, but these assessments were not all documented on the resident's record.

An interview with the home's DOC confirmed that any resident with impaired skin integrity should be assessed weekly by a registered staff member, and that those assessments should include every wound and should be documented in the assessment portion of the resident's electronic record. The DOC confirmed that some of resident #08's weekly skin and wound assessments are not present in the resident's electronic record. [s. 30. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee responds to the Residents' Council in writing within 10 days of receiving the advice.

A review of the Residents' Council meeting minutes for June 16, 2014, indicated the following concerns raised by the Residents' Council: stained coffee mugs, announcement of the food committee meetings, and smoke from smoking areas blowing into resident's open windows on George Unit. The Recommendations/Concerns Response Form was not initiated by the Residents' Council assistant for these concerns, and the response to these concerns was provided verbally during the next Residents' Council meeting.

Interviews with two active members of the Residents' Council confirmed that they do not receive anything from the home in writing.

An interview with the Residents' Council assistant confirmed that he/she initiates the Recommendations/Concerns Response Form after each meeting, forwards it to the responsible managers, and receives it back with the response within 10 days. However, the response is communicated verbally to the members of the Residents' Council at the next monthly meeting. [s. 57. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), that the licensee responds to the Family Council in writing within 10 days of receiving the advice.

An interview with the Family Council president revealed that the home does not always respond within 10 days to the concerns or recommendations raised by the Family Council.

An interview with the Family Council assistant confirmed that he/she usually waits for the Family Council president to email him/her the meeting minutes and the concern forms for the concerns raised during the last meeting. Usually, he/she receives an email during the week before the next meeting. He/She forwards the concern form to the responsible manager and manager responds on the form and he/she forwards that response to the president of the Family Council within 10 days of receiving the email. By the time the president of the Family Council receives the response it is more than 10 days after the concern was expressed at the Family Council meeting. [s. 60. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes:
- the date the complaint was received
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
- the final resolution, if any
- every date on which any response was provided to the complainant and a description of the response, and
- any response made by the complainant.

Staff interviews and record review confirmed that the staff did not prepare a documented record containing the above information, with regards to resident #04's complaint of missing nail clippers. Staff interviews and record review confirmed that staff did assist the resident to search for the nail clippers, but did not complete documentation of the complaint as per the home's usual process. [s. 101. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee shall ensure that the Director is informed of an injury in respect of which a person is taken to hospital no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

A record review revealed that resident #25 fell on an identified date in March 2014, and was sent to the hospital and admitted with an identified injury, of which the home was aware. The resident underwent surgery on a second identified date in March 2014.

A review of the corresponding Critical Incident (CI) Report #2630-000009-14 indicated that the home first submitted the CI to the Ministry of Health and Long-term Care (MOHLTC) on an identified third date and time in March 2014.

An interview with the DOC confirmed that the CI report was submitted to the MOHLTC on the third identified date in March 2014, and was not submitted within one day of the incident. [s. 107. (3) 4.]

2. The licensee has failed to ensure that where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, the Director under the LTCHA shall be informed of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

A record review indicated that resident #15 sustained a fall leading to hospitalization on an identified date and time in April 2014. Three days later, an identified member of the registered staff contacted the hospital and was informed that the resident had sustained an identified injury and had undergone surgery. The resident was readmitted to the home on a third identified date and time in April 2014. The home submitted the corresponding critical incident report on a fourth identified date and time in April 2014, more than 24 hours after readmission to the home. The resident's health condition declined post-operatively and the resident passed away later in April 2014.

An interview with a member of the registered staff revealed that the resident experienced a significant change in health condition following the incident.

The DOC confirmed that the MOHLTC was not notified once the home became aware that the injury resulted in a significant change in health status or within three business days after the occurrence of the incident. [s. 107. (3.1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

Observation of the narcotic drawer of the medication "B" cart on the Mill Unit 1 on January 6, 2014, revealed that non drug-related items were stored in the narcotic drawer. The inspector observed a box of disposable gloves and a labeled envelope containing 10 dollars stored in the narcotic drawer of the cart.
The registered staff member confirmed that only drugs or drug-related items should be stored in the cart, but the box of gloves was used to keep the drug cards upright in the cart, and the money was being stored in the cart for safe keeping. The staff member confirmed that staff sometimes store valuables in the narcotic box for safe keeping.

An interview with the home's DOC confirmed that non drug-related items should not be stored in the medication carts, and that valuables should be stored in the safe in the business office until family is contacted to pick them up. [s. 129. (1) (a)]

Issued on this 26th day of January, 2015

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

Original report signed by the inspector.