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

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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
Mar 29, 2018	2018_594624_0003	001761-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Bay Ridges
900 Sandy Beach Road PICKERING ON L1W 1Z4

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

BAIYE OROCK (624), JENNIFER BATTEN (672), SAMI JAROUR (570)

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): January 29, 30, 31, February 1, 2, 5, 6, and 7, 2018

The following logs were inspected concurrently:
Logs #017567-17 and #024274-17, related to two resident falls,
Logs #019539-17, #022513-17, and #027998-17, related to allegations of staff to resident abuse and/or neglect,
Log #023395-17, related to an allegation of resident to resident abuse, and
Logs #024878-17 and # 001502-18, related to disease outbreaks in the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Assistant Director of Care (ADOC), the Environmental Service Manager (ESM), the Resident Assessment Instrument (RAI) Coordinator, the Resident Service Coordinator, a Behavioral Support Ontario (BSO) Worker, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental/Housekeeping staff, Restorative/Program/Recreational Aides, a Cook/Dietary staff, the president of Residents' Council, residents, and family members.

A tour of the home was completed and observations were made of resident to resident interactions, staff to resident interactions during care provision, and medication administration. A review was also completed of residents' health records, medication incidents reports, the licensee's internal investigation records, disease outbreak line lists, annual evaluation records of the home’s infection prevention and control (IPAC) program, IPAC training records, Residents' Council meeting minutes, Professional Advisory Committee (PAC) meeting minutes, maintenance and housekeeping audits, housekeeping supply orders, joint health and safety committee minutes, as well as relevant policies and procedures related to nutrition and hydration, IPAC practices, zero tolerance of abuse and neglect, and falls management.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **4 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. 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 furnishings were kept clean and sanitary.

Inspector #672 made the following observations:
-On January 29, 2018, at approximately 1400 hours, the raised toilet seats in two identified rooms were dirty with dried feces. The walls in a hallway in a first identified home area were noted to be dirty, with spills down them in multiple places, which appeared to have been dried.
-On January 30, 2018, at approximately 1130 hours, the raised toilet seats in the two above rooms, continued to appear dirty with dried feces. The walls in the hallway in the same identified home area continued to be dirty, with spills down them in multiple places, which appeared to have been dried.
-On February 1, 2018, at 1245 hours, the floor of the spa on a second identified home area appeared dirty, with dirt/mud tracked in and stained onto the floor. The commode and the toilet were both soiled with dried feces.

During an interview on February 1, 2018, PSW #123 indicated that the identified spa was usually dirty, and the toilet and commodes were soiled "all the time".

On February 5, 2018, the following observations were made by Inspector #672:
-At 1010 hours, the commode and the toilet in the spa room on a third identified home area were both soiled with dried feces,
-At 1020 hours, the commode and the toilet in the spa room on the first identified home area were both soiled with dried feces,
-At 1040 hours, the raised toilet seats in the bathrooms of two identified rooms appeared soiled, with dried feces, and
-At 1140 hours, the floor of the spa room on the the first identified home area appeared dirty, with dirt/mud footprints and smudges visible on the floor, and the commode and the toilet were both soiled with dried feces.

During separate interviews, housekeepers #120, #125, and #128 all indicated that the expectation in the home was that every resident room was cleaned on a daily basis, but frequently that would not occur, due to time constraints. Housekeeper #120 further indicated that cleaning duties included the common areas, which included hallways, and that the home would often run out of cleaning supplies. Therefore cleaning chemicals would need to be substituted for tasks like cleaning the toilets, and that other tasks were

very difficult to complete, due to equipment either not working, or being in disrepair. Housekeeper #120 further indicated that the vacuum was broken, the broom assigned was too frayed to work properly, and the mops no longer held the heads properly, therefore the floors could not be cleaned appropriately. Inspector #672 observed housekeeper #120's broom, which appeared to be very jagged and frayed, along with the mop, which did not hold the mop heads well.

Housekeeper #125 and #128 indicated that when cleaning supplies were getting short, or were no longer available, this would be reported to the ESM, who would inform the staff that the items were ordered, and were awaiting delivery. Housekeeper #128 indicated that the vacuum was broken, the broom was also too frayed to work properly, the mops no longer held the heads properly, and the housekeeping carts were rarely stocked with the required amount of mop heads, therefore the floors could not be cleaned appropriately. Housekeeper #128 further indicated that the expectation was that the mop heads were to be changed after cleaning each room, due to infection control concerns. Inspector #672 observed housekeeper #128's broom, which appeared to be very jagged and frayed, along with the mop, which did not hold the mop heads well, and the bucket of mop heads. There were six mop heads in the bucket, for housekeeper #128 to utilize.

On February 5, 2018, a staff member approached Inspector #672, and brought forward concerns that resident rooms were not being cleaned on a daily basis, common areas such as spa rooms were not being cleaned more than one time per week, and lounge areas and furniture were not being cleaned at all. The staff member brought forward pictures, which depicted resident furniture as very dirty, with large amounts of food/crumbs/garbage items such as wrappers or packages under the cushions, and/or being soiled, with depictions of what appeared to be urine staining on the tops of some of the cushions.

On the same day, February 5, 2018, at 1600 hours, Inspector #672 toured a fourth resident home area. The following were observed:
-A grey chair appeared to have been wet at some point, and was stained. The couch's cushions appeared soiled and stained. When the cushions were moved, a very large amount of dirt/soiled food items/garbage was noted to be underneath.
-There were spills and dried food/fluid on the walls in the dining room. The undersides of many of the dining room tables had dried food items stuck to them. The chairs in the dining room had food/fluids spilled on them, with some staining.
In several identified rooms, the wall in the bedroom was dirty, with something spilled down it, and dried; the bathroom floor appeared dirty, with dirt/mud footprints and

smudges visible; and the bathroom floor appeared dirty, with dirt/mud footprints and smudges visible, and the toilet was soiled with dried feces.

On February 6, 2018, Inspector #672 toured an identified resident home area, and observed the following:
-The walls in the hallway appeared dirty, with spills down them.
-Cushions of a couch appeared to be soiled and stained. When the cushions were moved, a very large amount of dirt/soiled food items/garbage was noted to be underneath.
-There were spills and dried food/fluid on the walls in the dining room. The undersides of many of the dining room tables had dried food items stuck to them. The chairs in the dining room had food/fluids spilled on them, with some staining.
In several identified resident rooms, the following were observed:
- bedrooms walls appeared dirty, with spills down them, and the toilet was soiled,
- the bathroom floor appeared dirty, and the toilet was soiled,
- there was a large amount of dried glue down the entire outside and inside of the bedroom door frame,
- the bathroom floor appeared dirty,
- the bedroom walls were dirty, with spills down them, and the toilet was soiled,
- toilet was soiled with dried urine and feces,
- The mattress on the bed was worn and ripped down the middle, the bathroom floor appeared dirty, with dirt/mud footprints and smudges visible,
- the bathroom floor appeared dirty, with dirt/mud footprints and smudges visible, and the toilet was soiled with dried urine and feces, and
- the bedroom and bathroom floors appeared dirty, with dirt/mud footprints and smudges visible, and the toilet was soiled with dried urine and feces.

During an interview, the Environmental Services Manager (ESM) indicated that the expectation in the home was that every resident bedroom and bathroom were cleaned on a daily basis, that all housekeeping equipment was in an appropriate state of repair, and working condition, and that the home never ran short of supplies. The ESM further indicated they completed daily walk-abouts of the home, to assess for cleaning, and that audits were completed a minimum of two times per week. Inspector #672 interviewed the ESM on a subsequent date, confirming that the furniture was stained/soiled and in a state of disrepair, that the walls in the dining rooms and hallways were dirty, and that the floors were dirty on the first identified resident home area. The ESM further indicated that the areas mentioned above were not considered to be clean, or meeting the minimum expectations regarding cleanliness, infection control, and disinfection.

During an interview, the Executive Director (ED) indicated being unaware of any housekeeping concerns in the home, and felt that the home had been kept in a clean state. The ED further indicated being aware of some of the resident rooms which experienced malodours being present. The ED indicated that an identified floor was in need of being completely removed, but due to the home being in a disease outbreak, it was unable to bring in outside contractors to complete the work.

During an interview, the ESM indicated being aware of the malodourous condition of a specified room since June 2017, when audits were completed in June and July 2017. The ESM further indicated that audits would only be completed if a complaint was received, and did not become aware there was still a concern with odours until November/December, and had planned on changing the floors, but had to wait until the disease outbreak was over.

During another interview, the ED indicated that an identified room had been cleaned and the carpet shampooed. Inspector #672 observed the room again in the afternoon of an identified date, and found the room continued to have a lingering offensive odor. The ED indicated the carpet would be removed on an identified date, and replaced with a vinyl flooring instead, which could be cleaned more efficiently.

The licensee failed to ensure that the home and furnishings were kept clean and sanitary. [s. 15. (2) (a)]

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

On February 5, 2018 , Inspector #672 toured an identified resident home area, and made the following observations of several resident rooms in the identified home area:
-There was a hole in the ceiling, at the entrance to the identified resident home area, the size of approximately two ceiling tiles,
- there was a hole in the bedroom wall, measuring several inches in diameter, and the bathroom flooring was missing around the base of the toilet,
- there was a large hole in the bedroom wall, measuring approximately one foot in height and two and a half feet in length.
- there were holes in each of the bedroom walls, measuring several centimeters in perimeter,
- the seat on the toilet was much too small for the toilet, leaving a gap between the seat

and the base of the toilet of approximately one and a half centimeters. There was also a hole in the bathroom floor, measuring several centimeters,
- there was a hole in the bedroom wall, several centimeters in diameter, and a hole in the bathroom floor, measuring several centimeters as well,
- there were multiple holes in the bedroom wall, each measuring several centimeters, and
- there were holes in the bathroom floor, where the flooring was missing and the wood underneath was exposed, each being several centimeters in diameter.

During the initial tour of the home on January 29, 2018, Inspector #570 observed the shower room on another identified resident home area to have some damage to the lower wall, with corner beads exposed on the wall separating the toilet area from the shower area.

On February 6, 2018, Inspector #672 toured another resident home area, and made the following observations:
-The dining room walls were noted to have several areas with holes and gouges in the walls, measuring several centimeters in length,
-In an identified lounge area- there were four holes and gouges in two of the walls, which were several centimeters in diameter,
-In several resident rooms:
- the wall protector leading into the bathroom was broken and coming away from the wall; along with multiple gouges in the bathroom door,
- there was a large amount of what appeared to be dried industrial glue on the inner and outer aspect of the bedroom door frame, running from the top of the frame to the bottom. There were scratches and gouges in the bedroom and bathroom floors, several feet in length, and a hole in the bathroom floor under the sink, measuring several centimeters in diameter. The resident in the room complained that the flooring had been in the same condition since the day they moved into the room, more than one year prior.
- there was a large hole in the wall behind the bed, and a hole behind the toilet.
- there was a hole in the bedroom wall behind the bed, and the wall was gouged in multiple places behind the door.
- the walls were gouged in the bedroom, with multiple holes in the left bedroom wall, and above the light switch in the bathroom.
- there was a hole in the bedroom wall behind the recliner chair, and multiple holes in the bathroom floor.
- there were gouges in the bathroom floor.
- there was a large portion of the wallpaper missing behind the bed, and the rest of the

wallpaper hanging was frayed. There were also holes in the floor around the base of the toilet.
- the carpet and wall protector joining the bathroom wall was noted to be coming off.
- the paint in the bathroom was noted to be chipped in multiple places, and old repairs which had been painted over were mismatched to the main color of the walls, and
- there was a very large hole in the wall behind the bed and there was a large gouge/hole in the floor at the rear entrance to the elevator on the second floor, which caused Inspector #672 to trip, and fall into the SW wall.

Inspector #672 reviewed the maintenance documentation and audits for the entire 2017 year, which revealed that the ESM had conducted one audit of the flooring in the home in 2017, on August 10, 2017. This audit indicated that the ESM had identified one floor on an identified resident home area, and four floors on another identified resident home area which required replacing.

During an interview, the ESM indicated awareness of some of the areas noted by Inspector #672, but not all. The ESM further indicated that the home could only repair issues when funds were made available, and permission was given, and that all audits had been shared with the management team in the home. The ESM stated that the expectation in the home was that each resident room and common area was kept in a good state of repair, and did not consider the rooms on the two identified resident home areas to be in a good state of repair. The ESM indicated that it was difficult to keep up with all of the maintenance required within the home, due to not having an adequate amount of staff on the housekeeping and maintenance departments.

During an interview, the Executive Director (ED) indicated that the expectation in the home was that the ESM would complete daily walk-abouts of the building, auditing for areas of disrepair, and bringing those areas of concern forward to the team, along with an action plan. The ED further indicated an unawareness of the condition of the resident rooms and common areas on the the two identified resident home areas. Inspector #672 reviewed pictures taken of the areas in disrepair with the ED, who then indicated that the areas identified were not in a good state of repair.

The licensee has failed to ensure that the home and furnishings were maintained in a safe condition and in a good state of repair, on the identified resident home areas. [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, furnishings and equipment are kept clean, are maintained in a safe condition and are in a good state of repair, to be implemented voluntarily.

WN #2: 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 were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

On an identified date and time, Inspector #624 observed two different medications on the bedside table in resident #020's room.
During an interview, RPN #102 indicated to Inspector #624 that resident #020 had not been assessed to self administer medications, therefore the medication should not have been in the resident's room.

On the same date above, inspector #672 observed three different medications in resident #013's bathroom, and observed another medication on the counter in resident #008's bathroom. During an interview, RPN #104 indicated to Inspector #672 that residents #008 and #013 had not been assessed to self administer medications, therefore the medications should not have been in the residents' bathroom.

A week later, inspector #672 observed two different medications on the bathroom counter of resident #037's room; another medication on the counter in resident #038's bathroom; three containers of another medication on the shelf in resident #039's bathroom. During an interview, RPN #124 indicated to inspector #672 that residents #037, #038 and #039 had not been assessed to self administer medications and should not have medications stored in their respective rooms.

The licensee failed to ensure that drugs were stored in an area or a medication cart, which was used exclusively for drugs and drug-related supplies, related to residents #013, #020,#008, #037, #038, and #039. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #3: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, and that corrective action was taken, as necessary.

Review of the licensee's medication incidents and adverse drug reactions between a three month period in 2017, was conducted by Inspector #672. It was noted that five medication incidents occurred during that time period.

Inspector #672 reviewed the last two available quarterly Professional Advisory Committee (PAC) minutes from meetings held within a four month period in the year 2017. There was no documentation within the minutes which reflected that the medication incidents and adverse drug reactions were analyzed, or corrective action taken.

During an interview on an identified date, the Assistant Director of Care (ADOC) indicated to inspector #672 that the medication incidents from the previous quarter were discussed during the PAC meetings, but that the incidents were not analyzed. The ADOC further indicated that there was no documentation to reflect any corrective action plans, in an attempt to prevent further medication incidents from occurring.

The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, that corrective action was taken, and that a written record was kept of the documentation, review and analysis of the incidents as well as of the corrective actions taken. [s. 135. (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 ensure that, (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; and (b) corrective action is taken as necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

On an identified date and time in a specified Resident Home Area (RHA), inspector #570 observed PSW # 111 offering residents nourishment from the snack cart. The PSW was observed touching residents mobility aides, moving residents around the TV lounge, returning to the snack cart and continuing with providing nourishment to other residents without performing hand hygiene.

Two days later, inspector #624 while seating in another RHA nursing office, observed PSW #118 and PSW #119 working on the snack cart, giving out snacks and drinks to residents. Both PSW were observed going back and forth from the cart, assisting residents with their drinks, wiping residents mouth with tissues while not wearing any gloves, touching residents' wheelchairs and then returning to the snack carts without performing any hand hygiene. At a point during the observation, PSW #118 was observed cleaning a spill on the floor with bare hands and then returned to providing snacks to other residents without performing hand hygiene.

On the same day inspector #672 observed the morning nourishment pass on another RHA and PSW #111 was observed entering/exiting resident's rooms, providing nourishments to residents while removing used drinking glasses from two resident rooms. The PSW was not observed to perform any hand hygiene between these tasks and returned to providing snacks to other residents. During an interview with Inspector #672, PSW #111 indicated the licensee's expectation is that hands should be washed prior to beginning the nourishment pass, and are then sanitized upon exiting each resident room.

On the same day, inspector #624 interviewed both PSW #118 and #119 about the licensee's expectation on performing hand hygiene. PSW #118 stated that the expectation is to perform hand hygiene before starting the snack cart and then after finishing the snack cart service. PSW indicated unawareness that hand hygiene be

completed between residents when doing the snack cart. PSW #119 indicated that before starting the snack cart, hand hygiene has to be performed and after finishing the snack cart hand hygiene has to be performed. PSW #119 indicated that if returning from a dirty task, like cleaning the floor, hand hygiene should be performed before getting back to the snack cart. RPN #102 was questioned about the home's expectation regarding hand hygiene during snack service from the nourishment cart and the RPN indicated that the expectation is to have an alcohol-based hand rub container on the snack cart and PSW staff should be performing hand hygiene between residents as well as when moving from dirty to clean task.

On the same day, the Assistant Director of Care (ADOC) was interviewed by Inspector #624 about the home's expectation on hand hygiene during snack cart service and the ADOC indicated that staff should be performing hand hygiene between residents when doing the snack cart especially after touching the residents mobility aid or after being involved in any dirty task. This expectation was also confirmed by the Executive Director in a separate interview conducted on the same day with Inspector #624.

A day after talking to the ADOC, inspector #672 observed the morning nourishment pass on an identified RHA being completed by PSW #121. PSW #121 was observed to provide nourishment to residents in an identified room without completing hand hygiene, and then proceeded to serving the residents in the lounge area. During an interview of PSW #121 by inspector #672, the PSW indicated the expectation in the home is that hand hygiene is completed following serving each resident their nourishment.

Five days after talking to the DOC, inspector #672 observed part of the morning nourishment pass on an identified RHA being completed by PSW #126. Though a bottle of hand sanitizer was found on the snack cart, at no point during provision of snacks and drinks to several residents was the PSW observed to perform hand hygiene. During an interview of PSW #126 by inspector #672, the PSW indicated that the policy regarding hand hygiene during the nourishment pass was that hand hygiene was to be completed "at the beginning of the nourishment pass, then whenever your hands get dirty." On the same date at another RHA, inspector #672 observed the afternoon nourishment pass being completed by a PSW who was not observed to complete hand hygiene during the pass, despite assisting a resident to a table in the lounge area by pushing the resident's wheelchair. The PSW was also observed assisting another resident to a seat, by holding the resident by the arm before returning to the snack service with no performance of hand hygiene. During an interview with the PSW by inspector #672, the PSW indicated unawareness of what the policy indicated, in regards to hand hygiene during

nourishment.

A day later, at an identified RHA, inspector #672 observed the afternoon nourishment pass been completed by PSW #135 who was not observed to perform any hand hygiene while providing snacks and drinks to several residents. In an interview of PSW #135 by inspector #672, the PSW indicated that the policy instructs staff to perform hand hygiene at the beginning of nourishment pass only.

During this inspection and on several occasions, staff were observed performing hand hygiene during the provision of care to residents, appropriately donning and doffing personal protective equipment (PPE) on entry/exit of resident rooms that were on isolation, and a staff member was observed on several occasion/days to be performing high intensity cleaning. PSW staff were however not observed to be performing hand hygiene practices during snack services as detailed above.

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program in the home by not performing hand hygiene appropriately during the provision of snacks and drinks to residents. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written care plan for resident #018 sets out the planned care for the resident related to the use of a mobility aid.

As a result of an RQI triggered item, a review of clinical records for resident #018 was completed which indicated the resident was admitted to the home on and identified date with specified diagnoses.

On an identified date and time, inspector #624 observed resident #018 using a mobility aid in their room. On the same day, at a different time, inspector #624 observed resident #018 using the same mobility aid in a specified way, at another location.

The current written plan of care, at the time of the observations, for resident #018 was reviewed by inspector #570. The plan of care indicated that the resident uses a mobility aid in a specified way and at a specified time during the day. The plan of care did not indicate that the resident uses the mobility aid in the manner that had been observed by inspector #624 nor did it identify the purpose of the mobility aid. There was also no indication of any directions to staff regarding the use of the mobility aid and how the mobility aid is to be applied by staff.

On an identified date, during separate interviews, PSWs #107, and #108, both indicated to inspector #570 that resident #018 is using the mobility aid, applied in a particular manner for comfort and fall prevention. During separate interviews, RPNs #106 and #113, both indicated to inspector #570 that the resident uses the mobility aid for comfort, safety and fall prevent. Both RPNs #106, and #113 confirmed to inspector #570 that the use of the mobility aid was not included in the written plan of care.

During an interview on an identified date with the Executive Director (ED), the ED indicated to inspector #570 that the use of the mobility aid should be included in the plan of care for the resident.

The licensee did not ensure that the written plan of care for resident #018 sets out the planned care for the resident, specific to the mobility aid. [s. 6. (1) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a mobility aid as a PASD for resident #018 has been approved by
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

Related to resident #018 and the use of the mobility aid identified in WN #5 above, the licensee did not ensure that the use of mobility aid, in a specified way, had been approved by a physician, a registered nurse, a registered practical nurse, Occupational Therapist, or a Physiotherapist. [s. 33. (4) 3.]

2. The licensee has failed to ensure that the use of mobility aid as a PASD for resident #018 has been consented to by the resident or, if the resident was incapable, a substitute decision-maker (SDM) of the resident with authority to give that consent.

Related to resident #018 and the use of the mobility aid identified in WN #5 above, separate interviews were conducted with RPN #106 and #113 who both confirmed to inspector #570 that there was no documentation that resident #018 or the SDM of the resident consented for the use of the mobility aid as a PASD.

During an interview with the Executive Director (ED), the ED indicated to the inspector that mobility aids can be considered either as a restraint or a PASD and that the consent for its use should be obtained and kept on file.

The licensee did not ensure that the use of the mobility aid as a PASD for resident #018 had been consented to by the resident or by the SDM of the resident. [s. 33. (4) 4.]

WN #7: 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, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission, and of acquiring in the case of new items.

On an identified date, Inspector #570 made the following observations during the initial tour of the home:

On an identified resident home area, in the spa/bathing room, there were two used and unlabelled white hair brushes left on the vanity, next to the sink.

On another identified resident home area, in the spa/bathing room, there was an unlabelled, used white hairbrush and unlabelled nail clippers, on the vanity sink. In the shower room, there was an unlabelled white hair brush, with hair noted to be caught within, and an unlabelled set of nail clippers on the shelf with the supplies, including clean towels and incontinent products.

On a third identified resident home area, in the spa/bathing room, there was one white, unlabelled used hair brush on the vanity, next to the sink.

On a fouth identified resident home area, in the spa/bathing room, there was an unlabelled used black hair comb on the shelf next to the shower area. In the shower room was one used, unlabelled white hair brush, and one unlabelled set of nail clippers left on the shelf with incontinent products and clean towels.

On the same day, inspector #672 made the following observations on the third identified resident home area above:

In a specified resident room, there was an unlabelled white hair brush, two unlabelled white tooth brushes, three bottles of open and unlabelled mouth wash, an unlabelled tube of Chap Stick, an unlabelled electric razor, two unlabelled wash basins, two unlabelled slipper pans under the sink, and an unlabelled blue disposable razor in this shared bathroom, between residents #010 and #011.

In another resident room, there was an unlabelled blue disposable razor, an unlabelled jar of Nivea Moisturizer, an unlabelled urine collection "hat", and an unlabelled K basin in this shared bathroom for two residents.

A week later, Inspector #672 observed the spa room in the first identified resident home area above. On the counter beside the sink, was an unlabelled used white hair brush with black bristles, along with two unlabelled long black combs. The same day, inspector #672 also observed the spa room in another resident home area. On the counter beside the sink, was one used unlabelled white hair brush with black bristles.

During an interview, PSW #118 stated that the expectation in the home was that all personal items were labelled with the resident's name, if the item belonged to a specific resident. During another interview, PSW #123 stated the expectation in the home was that all personal items were labelled with the resident's name, and could not identify who the brush belonged to.

On another day and time, inspector #672 observed in a specified resident room unlabelled items in the shared bathroom, which included electric and disposable razors, and a white hair brush, all sitting on the bathroom counter. During an interview, PSW #123 indicated the expectation in the home was that all personal items were labelled with the resident's name on it, and was unable to state which resident the unlabelled items belonged to.

During an interview, the Executive Director indicated to inspector #672 that the expectation in the home was that all personal items were labelled with the resident's name.

The licensee failed to ensure that all residents had their personal items labelled. [s. 37. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Environmental Service Manager (ESM) had a postsecondary degree or diploma.

During an interview on an identified date and time, the ESM revealed to inspector #672 that they did not have a secondary degree or diploma, and had been working in the home for an identified period.

During an interview on an identified date, the Executive Director (ED) indicated that the ESM was the lead in the home for the maintenance and housekeeping department. The ED further indicated that the housekeeping and environmental services in the home were contracted to a third party company by Revera corporate office which is also responsible for securing and maintaining this contract.

In the same interview, the ED indicated that the third party company was responsible for the hiring, education, discipline, and termination of the housekeeping and environmental services employees, along with ensuring all hired employees possessed the required qualifications as legislated under the LTCHA, 2007. The ED indicated having assumed that the ESM met the minimum set educational requirement, as stated under the legislation. [s. 92. (2)]

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

Issued on this 13th day of April, 2018

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

Original report signed by the inspector.