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 prévue le Loi de 2007 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**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 22, 2015; | 2014_265526_0018 (A2) | H-001101-14 | Resident Quality Inspection |

### Licensee/Titulaire de permis

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive Georgetown ON L7G 2B8

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

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive Georgetown ON L7G 2B8

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

THERESA MCMILLAN (526) - (A2)

## Amended Inspection Summary/Résumé de l'inspection modifié

**Please be advised that RQI Inspection at The Bennett Health Care Centre, Inspection Number 2014_265526_0018, Log Number H-001101-14, has been amended. Specifically the following Compliance Order compliance dates have been amended as negotiated with and by the home:**

**CO #002: February 27, 2015**

**CO #003: February 27, 2015**

**CO #004: March 31, 2015**

**CO #005: February 27, 2015**

**CO #007: March 31, 2015**

**Theresa McMillan**
**Long Term Care Homes Inspector**
**Ministry of Health and Long Term Care**
**Performance Improvement and Compliance Branch**

**Issued on this 22 day of January 2015 (A2)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 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**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 22, 2015; | 2014_265526_0018 (A2) | H-001101-14 | Resident Quality Inspection |

### Licensee/Titulaire de permis

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive Georgetown ON L7G 2B8

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

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive Georgetown ON L7G 2B8

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

THERESA MCMILLAN (526) - (A2)

## Amended Inspection Summary/Résumé de l'inspection modifié

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

**This inspection was conducted on the following date(s): ~~September~~ August 19, 20, 21, 22, 25, 26, 27, 28 and 29, 2014.**

**Follow up inspections to Compliance Orders #001, #002 and #003 for Inspection number 2014_306510_0014 were conducted simultaneously with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Administrator's Assistant (AA), Resident Care Coordinator (RCC), Program Manager, Food Service Manager (FSM), Registered Dietitian (RD), Behaviour Support Ontario staff (BSO), registered staff including Registered Practical Nurses (RPN) and Registered Nurses (RN), non registered staff including Personal Support Workers (PSW) and Health Care Aids (HCA), dietary and housekeeping staff, residents and family members.**

**The following Inspection Protocols were used during this inspection:**

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
32 WN(s)
17 VPC(s)
8 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 |
|---|---|---|---|
| O.Reg 79/10 s. 17. (1) | CO #901 | 2014_265526_0018 | 526 |

## NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home was equipped with a functioning resident-staff communication and response system. Residents in the home were at risk for not having staff respond to their care and safety needs when it was identified on August 19 and 20, 2014 that the resident-staff communication and response system was not operational.

The home's resident-staff communication and response system included a paging device that, when activated, clearly indicated to staff where the signal was coming from. The system failed to alert staff on eight out of ten occasions when the resident-staff communication and response system was triggered.

A) On August 19, 2014, at 1400 hours the Long Term Care (LTC) Inspector triggered the resident-staff communication and response system at both the bed station and the washroom station for residents #029 and #032. The Personal Support Workers (PSWs) providing care to residents #029 and #032 confirmed that their paging devices were not activated when the resident's staff communication response system was triggered.

B) Staff confirmed that on August 19, 2014 they were aware that their paging devise was non functional, and continued to carry the pager for the remainder of their shift.

C) On August 19, 2014, at 1400 hours the inspector triggered the resident staff communication and response system at both the bed station and the washroom station for residents #028 and #031. PSW assigned to resident #028 and #031 reported to the inspector that they were not carrying their paging device. This PSW indicated that when they arrived at work, a paging device was not available for their use during their shift.

D) On August 20, 2014, at 1030 hours the inspector triggered the resident staff communication and response system for the resident washroom station for resident #032. The PSW assigned to this resident confirmed that their paging device was not activated when triggered.

E) On August 20, 2014, at 1015 hours, inspector triggered the resident staff communication and response system for resident #022. The PSW assigned to this resident confirmed that their paging device was not activated when triggered. The Administrator's Assistant confirmed that the paging device remained non functional.

F) On August 20, 2014 a PSW confirmed to the inspector that the non functioning of the paging devices was an ongoing issue in the home.

On August 20, 2014 an Immediate Compliance Order (#901) was issued that the licensee immediately ensure that staff responded when the resident-staff communication and response system was activated. The Compliance Order was complied with when the home instituted a temporary plan to add an additional staff person to the schedule. This staff person was to monitor the resident-staff communication and response system to ensure that staff responded when the system was activated.

Beginning on August 20, 2014, and in response to the Immediate Compliance Order # 901, an additional staff member was present for all shifts to monitor that the call bells were being answered.

The home's resident-staff communication and response system continued to malfunction for the remainder of the inspection until August 29, 2014.

A) Between August 20 and 29, 2014, the DOC, Administrative Assistant (AA) and staff confirmed that the system was unreliable.

B) On August 22, 2014, the washroom station in room 2043 was triggered and did not

activate the paging device for non registered staff.

C) On August 22, 2014, the DOC confirmed that the home's resident-staff communication and response system vendor stated that they did not have parts to repair the system.

D) Between Friday August 22, 2014 and Thursday August 28, 2014, the home had instituted an audit of the resident-staff communication and response system where staff were required to trigger the system at all resident bed and washroom stations during each shift. These records indicated that pagers were activated inconsistently between August 22 and 28, 2014 for bed and washroom stations in rooms: 2111, 2137A, 2106, 2021, 2023A, 2023B, 2031A, and bed station for 2045B, 2048, 2049. The DOC, and AA confirmed that the call bells were functioning inconsistently between these dates and at the time inspectors exited the home.

E) On August 29, 2014, the Administrative Assistant stated that call stations in room 2127 functioned intermittently despite the fact that staff found that they were functioning during the audit.

The Administrator, the AA and the DOC confirmed that the home was aware that the resident-staff communication and response system was not reliable and did not indicate, when activated, where the signal was coming from.

This non compliance was previously identified on October 28, 2013 as a VPC; on July 02, 2014, as a Compliance Order to submit and comply with a plan by August 08, 2014. The home's plan submitted to the Long Term Care (LTC) Insepctor indicated that many actions related to the Compliance Order had been completed such as staff education about mandatory requirements for the use of the paging device, the implementation of a process to ensure that staff carry their pagers, and how to monitor the system if it was found to be ineffective. However, the findings as noted above did not coincide with the implementation of the plan as laid out.

On August 19, 2014 the home was issued an Immediate Compliance Order to immediately ensure that staff responded when the resident-staff communication and response system was triggered. [s. 17. (1) (f)]

***Additional Required Actions:***

CO # - 001 was served on the licensee. CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

**(A2)The following order(s) have been amended:CO# 002**

---

**WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and

respected the resident's dignity.

A) During interview with the Long Term Care (LTC) Inspector on August 22, 2014, resident #003 stated that approximately six months previously, a staff person brought in something for them to eat in the evening. The resident stated that they preferred to wait to eat the snack until the end of the day. They stated that the staff person complained that it stopped the staff person from getting their work done and spoke using a tone of voice that was insulting. The resident stated that the comment was disturbing and caused them to change a familiar routine to suit a member of the staff. The resident stated "I've been living by that comment [they] made" and stated that they continued to feel upset about it. The resident did not mention this to the Administrator or other staff prior to the interview with the LTC Inspector on August 22, 2014.

The LTC Inspector informed the Administrator of the resident's concerns as noted above. The Administrator indicated that he had no previous knowledge of the incident. After being made aware, the Administrator indicated that he had a discussion with the resident about staff not being flexible about snack time and about handling the resident's preference in an unprofessional manner. According to the Administrator, the resident informed the Administrator that the resident wasn't aware that residents could refuse a request by the staff. The Administrator indicated to the LTC Inspector that he would take steps to follow up with staff about ensuring resident choice. Action with staff had not occurred by August 29, 2014.

B) On August 25, 2014, resident #038 stated that while a staff person was assisting the resident to transfer to sit on the toilet, they "flipped" them so that they moved and sat down too quickly. They felt that the staff person didn't do it right or give them the time that they needed to move safely and properly. The resident had a diagnosis that limited their mobility and slowed their movements while ambulating. The DOC investigated the incident, and removed the staff from providing care to resident #038. The DOC confirmed that residents should be afforded care that was respectful and that was individualized according to the resident's needs. [s. 3. (1) 1.]

2. The licensee failed to ensure that residents' rights to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs was fully respected.

A) Resident #003's plan of care directed staff to assist them with toileting. On August 21, 2014, resident #003 stated that there had been times when they would alert the

nursing staff using the resident-staff communication and response system that they needed to have a bowel movement on the toilet. The resident stated that after activating the system, they would wait at the door for the staff to come. They stated that there were times when the staff took too long and they were incontinent. The resident stated they didn't like sitting in feces and felt embarrassed.

B) Between August 22 and 28, 2014 resident #038, #020, #300, and #310 informed the Inspector that resident #024 would repeatedly wander into their rooms both when they were awake and asleep. They stated that if they asked resident #024 to leave, the resident was verbally abusive and made gestures toward them that frightened them. These residents had complained to the home about their fears. Management of resident #024's responsive behaviours included the use of door guards and gentle persuasion techniques if the resident were to wander into a co resident's room. Residents stated that despite these measures, resident #024 continued to [redacted] demonstrate responsive behaviours. RW they continued to feel afraid.

Registered staff, the DOC and the Administrator confirmed that resident #024 continued to wander into co-residents' rooms and that some residents were afraid of them [redacted] despite measures in effect. They stated that they had not consider the needs of the residents who were victims of the responsive behaviours and had not addressed their fears, concerns and need for protection. [s. 3. (1) 4.]

3. The licensee failed to ensure that the resident's right to be afforded privacy in treatment was fully respected and promoted, in relation to the following: [3(1)8].

On August 27, 2014 at 1650hrs resident #021 was not afforded the right to privacy in treatment when a registered practical nurse (RPN) was noted to administer an injection into the resident's abdomen in a public area. Resident #021 was noted to be sitting in the area in front of the nursing station that was used as a gathering place for residents and there were several residents and staff in the area. The RPN was observed to raise the resident's shirt, exposed the resident's abdomen and injected medication into the resident's abdomen. [s. 3. (1) 8.]

4. The licensee failed to ensure that the right of every resident to have his or her personal health information kept confidential was fully respected and promoted, in relation to the following: [3(1)11iv].

Fourteen residents did not have their personal health information kept confidential

when, on August 26, 2014 at 1010hrs a resident was noted to have picked up the "Doctors Round Sheet" for the week of August 19, 2014 to August 26, 2014 (East Wing) and was reviewing the information that had been documented. The document contained the names of 34 residents. For 14 of those residents, personal health information was documented that included laboratory test results, bowel care requirements, diagnostic procedures results as well as issues related to medications, responsive behaviours and resident falls. [s. 3. (1) 11. iv.]

***Additional Required Actions:***

**CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following 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; 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs; and 11 iv. Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act,, to be implemented voluntarily.***

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations**
**Every licensee of a long-term care home shall ensure that,**
**(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and**
**(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents who were at risk of harm or who were harmed as a result of a resident's behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

A) Review of resident #024's Resident Assessment Instrument Minimum Data Set (RAI MDS) and associated Resident Assessment Protocol (RAP) completed in 2014 indicated that the resident "exhibited wandering into other residents' rooms", and "may become verbally and physically abusive (may strike out when asked for [their] cooperation with care)". Interview with registered staff and review of the resident's health record indicated that the resident's responsive behaviours had worsened since the previous (RAI MDS quarterly assessment.

Interviews with registered and non registered staff, the DOC and the Administrator confirmed that the resident exhibited wandering into other residents' rooms, verbal and physical aggression and gestures that intimidated and frightened other residents. Medical consultation by the psychogeriatric outreach team that occurred one month prior to the RAI MDS assessment noted above included recommendations on how to manage resident #024's responsive behaviours in relation to other residents. The Behavioural Supports Ontario (BSO) staff and the DOC confirmed that the recommendations had not been followed. They confirmed that resident #024's plan of care did not address minimizing risk to harm of other residents in the home.

B) During an interview with the LTC Inspector on August 25, 2014, resident #038 reported that resident #024 frequently wandered into their room while they were getting dressed in the morning, and while they were sitting next to their bed in a wheelchair. When resident #038 told resident #024 to "get out", resident #024 formed a fist with their hand and stated "I'll get you out"; this frightened resident #038.

Resident #038 stated they had been complaining about their fear and upset to the staff for a six month time period. Resident #038 stated that the DOC and the Administrator instructed them to trigger the staff-resident communication response system (call bell) if the resident entered their room. Resident #038 stated that the call bell system was not functioning consistently, and due to their limited mobility, they may not be able to reach the 'call bell' to alert staff, or to get out of the room without becoming injured first; this had further contributed to their fear. Progress notes, non registered staff and the DOC confirmed that resident #038 called police on July 23, 2014 due to their concerns about resident #024.

C) On August 28, 2014, residents #020, #300, #310 informed the LTC Inspector that resident #024 would wander into their rooms during the past six months, was verbally abusive and made gestures toward them that frightened them. They stated that after they had complained to the home about their fears, the resident continued to wander into their rooms and they continued to feel afraid.

The DOC and Administrator verified that they had not considered the harmful effects that resident #024's responsive behaviour was having on other residents living in the home. They confirmed that procedures and interventions currently in place did not assist residents who were at risk of harm or who were harmed as a result of a resident's behaviours. The risk of altercations and potentially harmful interactions between and among resident #024 and other residents in the home had not been minimized. [s. 55. (a)]

***Additional Required Actions:***

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

**(A2)The following order(s) have been amended:CO# 003**

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following:**

**s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,**
**(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).**

**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 failed to ensure that, as part of an organized program of maintenance services, that there were schedules and procedures in place for routine, preventative and remedial maintenance in the home.

On August 20, 2014, the Administrator and the Administrator's Assistant (AA) confirmed that they were jointly responsible for ensuring that the home was maintained according to legislative requirements. They stated that the programme involved requisitioning services to different suppliers including Georgetown and District Memorial Hospital. They stated that the home had not developed or maintained schedules and procedures for routine, preventive and remedial maintenance in the home and could not provide documentation of any maintenance schedules or procedures developed by the home in accordance with legislative requirements.

A) On August 20, 2014, the floor tiles in washrooms for resident rooms 2126 and 2128 were observed to be separating and lifting and had black debris between the tiles.

The Administrative Assistant (AA) verified that the home did not have a routine or preventative schedule or procedure for maintenance of resident rooms or washrooms.

B) On August 26, 2014, LTC Inspector #527 observed a resident in the process of sitting on a chair located outside of the main desk in the lobby near the Administrator's office. The chair was broken and one leg was shorter than the others. As the resident went to sit down, the chair tilted in the direction of the the broken leg and the resident began to fall. The LTC Inspector quickly assisted the resident and alerted staff that the resident was about to fall. The AA verified that there was no routine or preventative maintenance of the home's furniture that would identify furniture in disrepair prior to an injury occurring.

C) Between August 19 and 29, 2014, inspectors observed that the resident-staff communication and response system was not in good repair. The system involved being activated at a station and then staff were alerted by a light in the hall that began to flash silently and by the staff person's paging device being triggered with a sound and information about the source of the alarm activation.

Inspectors observed that resident bed and washroom stations were triggering staff pagers inconsistently. On August 19 and 20, 2014, the system failed to alert staff on eight out of ten occasions when the resident-staff communication and response system was triggered. Between August 22 and 28, 16 out of 116 call stations in the home were not triggering staff paging devices consistently.

The Administrator, the AA and the DOC confirmed that the home was aware that the resident-staff communication and response system was not functioning properly and that there had been no schedules or procedures in place for routine, preventive and remedial maintenance of the system. [s. 90. (1) (b)]

2. The licensee 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.

On August 20, 2014 the Administrator of the home and the Administrator's Assistant (AA) confirmed that they were jointly responsible for maintaining the home.

A) The Administator and the AA described the process of maintaining equipment, devices, assistive devices and positioning aids in the home as responsive and that the process did not consistently ensure that equipment was kept in good repair. The home

relied on staff to identify broken equipment as they were using it, and to make an entry in the home's "Staff Maintenance Request" Log book. The AA described the process staff were to use when completing the log book and confirmed that the home did not maintain notes or procedures that ensured that equipment was in good repair.

The AA stated that that if a maintenance issue was not identified by staff, staff may continue to use the equipment, device, assistive aid and positioning aid without realizing that it was in poor repair.

Review of the home's maintenance log indicated that seven resident beds being used by residents in the home were noted as being in poor repair on the following dates;
i) room 2046 noted on July 4 and 8, 2014;
ii) room 2040 noted on July 6;
iii) room 2028 noted on July 16, 2014;
iv) room 2023 noted on July 21 and 27, 2014;
v) room 2129 noted on July 29, 2014;
vi) room 2105 noted on August 3 and 18, 2014; and
vii) room 2034 noted on August 26, 2014.

In each case, there was no entry in the Maintenance Log book that the issue had been resolved or completed and this was verified by the AA. In fact, the AA verified that the home did not routinely return to the maintenance issue to determine whether repairs and maintenance had been completed. Out of at least 275 maintenance issues entered into the maintenance log between November 1, 2013 and August 29, 2014, four had entries that the issue had been completed or resolved. [s. 90. (2) (b)]

***Additional Required Actions:***

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

**(A2)The following order(s) have been amended:CO# 004**

***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 as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that (b) there are schedules and procedures in place for routine, preventive and remedial maintenance,, to be implemented voluntarily.***

---

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that when bed rails were used the resident was assessed in accordance with evidenced-based practices to minimize risk to the resident: [15(1) (a)].

The DOC confirmed that when bed rails were used for residents #003, #031, #032, #038 and #400, that the residents were not assessed for the use of those bed rails. On August 25, 2014 the PSW providing care for resident #003 confirmed that the two quarter rails that were affixed to the resident's bed were used whenever the resident was in bed. On August 19, 2014 resident #031 was noted to be in bed with two quarter rails in the active position. On August 25, 2014 the PSW providing care for resident #032 confirmed that the two quarter rails affixed to the resident's bed were used whenever the resident was in bed. On August 25, 2014 the PSW providing care to resident #038 confirmed that the two quarter rails affixed to the resident's bed were used whenever the resident was in bed. On August 19, 2014 resident #400 was noted to be in bed with two quarter rails in the active position. [s. 15. (1) (a)]

***Additional Required Actions:***

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

**(A2)The following order(s) have been amended:CO# 005**

---

**WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that the persons who had received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

A) Infection Prevention and Control (IPAC): When reviewing the IPAC staff training records regarding hand hygiene; modes of infection transmission; cleaning and disinfection practices; and the use of personal protective equipment, there were 43 out of a total of 93 staff in the home trained. In 2013 the total number of staff trained in infection prevention and control measures was 42, and in 2012 the total number of staff trained in infection prevention and control measures was 22. The DOC and the Resident Care Coordinator (RCC) as the co-leads for the IPAC Program confirmed that not all staff have been trained for infection prevention and control. (527)

B) Prevention of Abuse, Neglect and Retaliation: The licensee failed to ensure that all staff had received retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protections in accordance with O. Reg. 221(2). Five

staff who were interviewed stated that they had not received annual training related to the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protections. Two staff stated that they had not received training in the past five years. The home was unable to provide documentation of the content of the retraining as described above or staff sign up sheets for this staff training. The DOC confirmed that the home had not ensured that all staff who provided direct care to residents had received retraining relating to the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protections annually. (526)

C) Minimizing of Restraints: The licensee did not ensure that all staff who provided direct care to residents received annual retraining in accordance with O.Reg. 79/10 219(1), in relation to the following: [76(7) (4)]. The Director of Care confirmed that staff who provided direct care to residents had not received retraining in relation to minimizing the restraining of residents and, where restraining was necessary how to do so in accordance with the Act and the regulations in 2013 because training was not offered. [s. 76. (4)]

2. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the following areas:

A) Skin and wound Care: In reviewing the home's training records there were no records for skin and wound care training in 2013. In 2014 there were five registered staff and seventeen PSWs who attended training on January 8, 2014. The training was provided by the home's vendor of skin and wound care products and did not include training related to the Skin and Wound Care Program; the DOC and Resident Care Coordinator (RCC) confirmed this. One RN confirmed they had no training during the home's orientation as a new employee, and an RPN confirmed they had no Skin and Wound Care training in over one and a half years.

B) Continence Care: During review of the home's documentation related to the Continence Care Program, no records were found to support that annual training was provided to direct care providers. The PSWs, RNs, RPNs interviewed confirmed they had not received annual retraining related to the home's Continence Care Program. The RCC and the DOC also confirmed that direct care providers had not received annual retraining related to the home's Continence Care Program. [s. 76. (7) 6.]

***Additional Required Actions:***

**CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

---

**WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 84. s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.**

**Findings/Faits saillants :**

1. The licensee failed to develop and implement a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care, services, programs and goods provided to residents of the home.

The home's policy for "Quality Process" 1.2: 4.0 "Quality Indicators", 5.0 "Quality Audits", 6.0 "Quality Projects", 7.0 "Benchmarking", and 8.0 "Risk Management" last revised on August 1, 2014 directed staff in the implementation of the home's quality system. This included collecting, recording analyzing and evaluating data for quality indicators and conducting audits; reporting results to staff, teams and the Board; defining solutions to problems identified; taking steps to improve care; and risk management including staff education.

Between August 19 and 29, 2014 the quality improvement and utilization review system was noted to have the following deficiencies:

A) Compliance Orders: The following Compliance Orders issued on July 2, 2014 were not complied with as specified in the Orders by August 8, 2014 and at the time of this inspection:

i) #001 r. 17.(1) Resident-staff communication and response system; an Immediate

Compliance Order #901 was issued during this inspection
ii) #002 r. 90.(2) Equipment properly maintained; and
iii) #003 s. 3. (1) Residents' Rights

B) Policies not developed: Policies and procedures for the following areas were not developed:

i) Complaints Procedure (s. 21)
ii) Responsive Behaviours (r. 53(1))
iii) Maintenance Services (r. 90)
iv) Emergency Plans (r. 230(4)viii)

C) Policies not complied with: Policies and procedures in the following areas were not complied with:

i) Infection Prevention and Control (r. 8.(b))
ii) Continence Care and Bowel Management (r. 8.(b))
iii) Skin and Wound Care (r. 8.(b))
iv) Measurement of Vital Signs (r. 8.(b))
v) Minimizing Restraints (r. 29(1)(b))
vi) Prevention of Abuse and Neglect (s. 20(1))

D) Evaluation: Program evaluations were not conducted for the following areas for at least the past two years:

i) Skin and Wound Care Programme (r. 30(1)3)
ii) Continence Care and Bowel Management (r. 30(1)3 and r. 51(1)5)
iii) Responsive Behaviours (r. 53(3)(b)
iv) Prevention of Abuse and Neglect (r. 99)
v) Dealing with Complaints (r. 101(3))
vi) Infection Prevention and control (r. 229(6))

E) Training: Retraining was not provided to staff in the home in the following areas:

i) Infection Prevention and Control
ii) Prevention of Abuse and Neglect
iii) Minimizing Restraints
iv) Skin and wound Care
v) Continence Care and Bowel Management

The Director of Care confirmed the above deficiencies in the home's quality improvement and utilization review system. She confirmed that policy development and implementation, program evaluation and staff training had not been consistently integrated on an ongoing basis into the home's operations.

The Administrator confirmed that the home could not provide data regarding the implementation of the home's quality program. He also confirmed that the home had not conducted audit reviews, discussed quality improvements with residents, family members or staff, and had not developed plans for improvements. [s. 84.]

***Additional Required Actions:***

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

**(A2)The following order(s) have been amended:CO# 007**

---

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

**Specifically failed to comply with the following:**

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

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that the written plan of care for residents set out clear directions to staff and others who provided direct care to the resident.

A) The document which the registered staff used to direct the care for resident #009, which was known as the "care plan" identified that the resident was to have a treatment for three days. It further directed registered staff that an external agency RN would attend the home each of the three days to administer the treatment. Between August 25 to 29, 2014, the resident was not observed to receive the treatment. In

reviewing the resident's clinical record, the resident's condition resolved and a physician's order indicated that the treatment was discontinued in May 2014. The Resident Care Coordinator (RCC) and the Charge Nurse confirmed the resident did not require the treatment and the care plan was outdated. (527)

B) Resident #037 was observed by the LTC Inspector to have difficulty during meals on two occasions during August 25 and 26, 2014. On interview with the LTC inspector, the resident stated they had difficulty with their supper meal on August 27, 2014. Staff confirmed that the resident had difficulty while eating.

Review of resident #037's clinical records indicated that the resident was assessed by a speech language pathologist (SLP) in August, 2014. The SLP made recommendations for the resident. Registered staff confirmed that the resident benefited when staff followed the SPL's recommendations. The document the home referred to as the written care plan used by registered staff and the kardex used by PSWs did not include the recommendations made by the SLP. Registered staff confirmed this and confirmed that the care plan did not provide clear direction to staff. [s. 6. (1) (c)]

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

Resident #024's Resident Assessment Protocol (RAP) of the RAI MDS assessment conducted during 2014 indicated that the resident exhibited responsive behaviours. There was no mention in this assessment that the resident exhibited responsive behaviours toward co-residents. A psychogeriatric consultation note dated one month earlier indicated that staff in the home were concerned about the resident exhibiting responsive behaviours toward co residents.

The Behavioural Support Office (BSO) staff person interviewed by the LTC Inspector indicated that resident #024's responsive behaviours toward co residents were not included in the most recent resident full RAI MDS. They confirmed that staff did not collaborate so that their assessments were integrated, consistent with and complement each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the following were documented: 1) the provision of care as set out in the plan of care;

A) The plan of care for resident #110 identified measures to prevent skin breakdown and to capture any skin changes on a daily basis. There was no documentation of the following interventions for the resident to indicate whether care was provided as specified in the plan of care.

i) Resident #110 was to have a strategy to promote skin integrity implemented while the resident was in bed. In reviewing the resident's clinical record, the documentation on five days in 2014 reflected that the strategy was used only once within 24 hours. The PSWs confirmed that there was no documentation to indicate whether care had been provided to the resident as outlined in the plan of care.

ii) Resident #110 required skin observations every shift and it was not documented in the clinical record that the resident's skin was checked every shift. There was no documentation on five days in 2014 that the resident's skin was checked every shift. The PSWs confirmed that there was no documentation to indicate that care had been provided to the resident as outlined in the plan of care.

B) The plan of care for resident #009 identified measures to prevent skin breakdown for the resident and to capture any skin changes on a daily basis. There was no documentation of the following interventions for the resident to indicate that the care was provided as specified in the plan of care.

i) The plan of care included an intervention to promote skin integrity when resident #009 was resting in bed and while up in wheelchair. In reviewing the resident's clinical record there was no documentation that this intervention was performed on eight shifts in 2014. The PSWs confirmed that there was no documentation to indicate whether care had been provided to the resident as outlined in the plan of care.

ii) The PSWs were required to conduct skin observations for resident #009 on each shift. In reviewing the resident's clinical record there was no documentation that a skin observation was conducted on 10 shifts in 2014. The PSWs confirmed that there was no documentation to indicate whether care had been provided to the resident as outlined in the plan of care.

iii) The plan of care identified that resident #009 was to be re-positioned every hour while in the wheelchair to promote skin integrity. In reviewing the resident's clinical record there was no documentation that this intervention was performed on nine days in 2014. The PSWs confirmed that there was was no documentation to indicate whether care had been provided to the resident as outlined in the plan of care.

C) The plan of care for resident #035 identified measures to prevent skin breakdown for the resident and to capture any skin changes on a daily basis. There was no documentation of the following interventions for the resident to indicate whether care had been provided to the resident as outlined in the plan of care.

i) Resident #035 required turning and repositioning every two hours. Review of resident health records indicated that over 29 consecutive days in 2014, no documentation to indicate whether care had been provided to the resident was found. The PSWs confirmed that there was no documentation and could not verify that care had been provided to the resident as outlined in the plan of care.

ii) Resident #035 required skin observations every shift. There was no documentation on 10 days during a month in 2014 that skin observations had been implemented. The PSWs confirmed that there was no documentation and could not verify that care had been provided to the resident as outlined in the plan of care. (527) [s. 6. (9) 1.]

4. The licensee failed to ensure that resident #013's plan of care was revised when the care in the plan was no longer necessary.

A) On August 22, 27, and 28, 2014, resident #013 was observed not wearing glasses. The documents used to direct staff for resident care, known as the care plan and kardex, stated that the resident was to wear glasses. The resident's family stated the resident had not worn glasses for approximately two years. PSW's reported that the resident had not worn glasses for approximately two years. Registered staff stated the resident no longer required glasses. [s. 6. (10) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 1) there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; 2) staff and others involved i the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; 3) the provision of the care set out in the plan of care is documented; and 4) residents are reassessed and the plan of care reviewed and revised at lease every six months and at any other time when the residents' care needs change or care set out inthe plan is no longer necessary,, to be implemented voluntarily.***

---

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. Where the Act or Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

A) The licensee failed to ensure that the "Skin and Wound Care Program, number 4.16" last revised June 2013, was complied with.

i) The home's Skin and Wound Care Program policy identified the role of the Skin Care Coordinator, which included collecting data, analyzing statistics, identifing trends, evaluating outcomes and presents quarterly statistics to the interdisciplinary

committee. The home was unable to provide quarterly statistics. The DOC and the Resident Care Coordinator confirmed that the quarterly statistics had not been analyzed, identified trends, evaluated outcomes or presented to the interdisciplinary committee on a quarterly basis, therefore they were not in compliance with the policy.

ii) The home's policy indicated that the role of the Skin Care Coordinator included education of health care providers regarding best practices to reduce risk factors and prevent skin breakdown. The only education provided in 2013 and 2014, based on the home's records, was January 8, 2014. RNs, RPNs, and PSWs confirmed they have not been receiving education at least annually for Skin and Wound Care according to their policy.

iii) The home's Skin and Wound Care Program policy identified that the registered staff were expected to complete a head-to-toe assessment and Braden Scale within 24 hours of admission. Resident #110 did not have a head-to-toe assessment conducted until seven days after they were admitted to the home, and the Braden Scale was not conducted until 15 days after their admission. The RN, RPN and Resident Care Coordinator confirmed that the registered staff did not conduct the head-to-toe assessment and Braden Scale for the new admission, resident #110, in accordance with their program policies.

iv) The home's Skin and Wound Care Program policy identified that the registered staff were expected to conduct the Braden Scale for predicting pressure score risk. The frequency was based on the level of risk, which included that if a resident was high risk, the Braden Scale would be conducted, at a minimum, monthly. Resident #009 and #035 were identified by the registered staff as high risk for skin breakdown, and neither resident had a Braden Scale conducted based on a review of the residents' clinical records. The registered staff confirmed that they had not conducted a Braden Scale on these residents in the last couple of years, and were not aware that they were expected to. (527)

B) The home's policy "Routine Precautions, section 2.1" revised February 2014 identified the administrative controls, which were measures the home was to put into place to protect staff and residents from infection. The policy stated that infection prevention and control education was to be provided to all staff, especially those providing direct care, during orientation and as ongoing continuing education on an annual and as needed basis. Review of the home's documentation and training records indicated that 43 out of 93 staff were trained this past year. The RCC and the DOC confirmed this and that the home did not comply with their policy for staff

education and training. (527)

C) The home's policy "Surveillance, section 1.3" revised February 2014 indicated that the home was to perform two types of surveillance, which included process and outcome surveillance and analysis. The policy stated that these measures reflected the efficacy of the home's infection prevention and control program in protecting the residents. The home's policy identified process and surveillance indicators but did not provide documentation of the analysis, outcome and/or actions resulting from the evaluation of the indicators. This was confirmed by the co-leads for the Infection Prevention and Control Program and they confirmed that they did not comply with their policy. (527)

D) The licensee failed to ensure that their policy related to obtaining heights annually was complied with. The home's policy, titled "Resident Assessments and Vital Signs" last revised May 2012, stated that heights were to be taken annually. Clinical documentation was reviewed for resident #002, #013, and #035.

i) Resident #002 was admitted to the home in 2012. Their most recent height was recorded in 2012. No heights were recorded for 2013 and 2014.

ii) Resident #013, was admitted to the home in 2011. Their most recent height was recorded in 2011. No heights were recorded for 2012, 2013, and 2014.

iii) Resident #035 was admitted to the home in 2007. Their most recent height was recorded in 2010. No heights were recorded for 2011, 2012, 2013, and 2014.

Registered staff reported that the heights for resident #002, #013, and #035 were not taken annually. The Registered Dietitian confirmed that heights were to be taken annually. (585)

E) The licensee failed to ensure the "Continence Care Program policy, number 4.10", dated June 2012 was complied with.

i) The policy identified that the interdisciplinary team should conduct bowel and bladder continence assessment within seven days of a new admission, following any change in the resident's condition that affected continence, and quarterly. Staff did not conduct the continence assessments according to the policy for residents #001, #012 and #031.

ii) The policy identified that the Continence Care Program was to be reviewed annually to determine effectiveness of the program and to identify changes to improve the program in a written evaluation and provided to the Quality Management Committee annually. There was no annual evaluation found in the home's documentation. The RCC and the DOC confirmed the Continence Care Program was not evaluated annually and that there was no written evaluation provided to the home's Quality Management Committee.

iii) The policy also identified that the Continence Care Program Team should meet every two weeks and more frequently as required. The home was only able to provide meeting minutes from June 6, 2013, August 15, 2013 and May 9, 2014. The RCC, the DOC and one of the team members confirmed the committee was not meeting every two weeks as outlined in the policy. [s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee ensures that the plan, policy, protocol, procedure, strategy or system(b) is complied with,, to be implemented voluntarily.***

---

**WN #10: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that a written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy regarding "Resident Rights and Safety, 4.1.2": "Abuse and Neglect Prevention" last reviewed June 2012 stated "Annually, the Home shall complete an interdisciplinary evaluation to determine the effectiveness of the Homes policy to promote Zero Tolerance and what changes and improvements are required to prevent further occurrences. The results of the analysis of each incident of abuse or neglect are considered during the annual evaluation. Areas of concern or trends are identified and changes and improvements to policy and practice developed and are promptly implemented. The home shall ensure that documentation of the evaluation, including the date of evaluation, names of persons anticipating and date that changes and improvements were implemented is maintained in the Home". The DOC confirmed that this policy had not been followed as no annual evaluation had been completed. [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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.***

---

**WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home had written procedures that complied with the regulations for initiating complaints to the licensee and for how the licensee was to deal with complaints.

A) Resident #004 had personal items and clothing missing as reported to the home's staff by the Power of Attorney (POA). There were no Complaints policy and procedures in place in the home. The staff interviewed did not know if they had a Complaint policy and procedures, and were not able to provide an overview of the Complaints process in the home. The DOC confirmed the staff had not notified her of the POA's complaint, and confirmed there was no Complaint Log of the resident's missing clothing and personal items. (527)

B) The home was unable to provide the LTC Inspector with policies or procedures for initiating complaints to the licensee and for how the licensee was to deal with complaints. The DOC confirmed the home did not have written policies or procedures for initiating and dealing with complaints according to the regulations. [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 there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints, to be implemented voluntarily.***

---

**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

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

**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 failed to ensure that the required programs under section 8 to 16 of the Act, and under section 48 of the regulation were evaluated and updated at least annually in accordance with evidence-based practices and, or in accordance with prevailing practices.

A) Review of the home's Skin and Wound Care Program indicated that the program was last updated June 2012. The DOC stated that the home had not participated in an annual program review for the Skin and Wound Care Program, and the program was not evaluated or updated annually in accordance with evidence-based practices, or in accordance with prevailing practices. In addition, the Resident Care Coordinator (RCC) confirmed there was no annual evaluation of the Skin and Wound Care Program accordance with evidence-based practices, or in accordance with prevailing practices. (527)

B) The home's Continence Care Program was last updated June 2012 as identified in the home's documentation. The RCC and the DOC confirmed there was no annual evaluation of the Continence Care Program in accordance with evidence-based practices, or in accordance with prevailing practices. [s. 30. (1) 3.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including resident's responses to interventions were documented.

Clinical records indicated that resident #037 was experiencing ongoing difficulties at meals. The resident was assessed in 2014 by a Speech Language Pathologist (SLP) who made recommendations for the resident. Clinical documentation following the assessment and recommendations did not show the resident's response to the recommended intervention. Registered staff confirmed that the response to the intervention was not documented. [s. 30. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and 30(2) 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, to be implemented voluntarily.***

---

**WN #13: 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,**
**(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,**
**(i) within 24 hours of the resident's admission,**
**(ii) upon any return of the resident from hospital, and**
**(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #110 received a skin assessment by a member of the registered nursing staff within 24 hours of the resident's admission.

Resident #110 was admitted to the home in 2014. Clinical records indicated that at that time, the resident had altered skin integrity on four different areas on their body. There was no skin assessment conducted by a member of the registered nursing staff using a clinically appropriate instrument until seven days after admission to the home. The Braden scale was not conducted until 15 days post-admission to the home. The RCC and the Charge Nurse confirmed that a skin assessment by a member of the registered nursing staff was not conducted within 24 hours of the resident's admission. [s. 50. (2) (a) (i)]

2. The licensee did not ensure that (i) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin

assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, and (iv) was reassessed at least weekly by a member of the registered nursing staff.

A) Resident #009 was exhibiting altered skin integrity and did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment since April 2014, and it was not reassessed at least weekly by a member of the registered nursing staff.

In reviewing the resident's clinical record there was no documentation of skin assessments and no weekly re-assessments by registered staff. The RCC and the registered staff confirmed that the resident did not receive a skin assessment using a clinically appropriate instrument designed for skin and wound assessments, and that reassessments were not conducted at least weekly.

B) Resident #035 was exhibiting altered skin integrity and did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment since October 2013, and it was not reassessed at least weekly by a member of the registered nursing staff. In reviewing the resident's clinical record there were no skin assessments and no weekly re-assessments by registered staff. The RCC and the registered staff confirmed that the resident did not receive a skin assessment using a clinically appropriate instrument designed for skin and wound assessments, and that reassessments were not conducted at least weekly. [s. 50. (2) (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 50.(2)(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff (i) within 24 hours of the resident's admission; 50(2)(b)(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; and (iv )a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

---

**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

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

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

**Findings/Faits saillants :**

1. The licensee did not ensure that the Continence Care Program conducted an annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff.

In reviewing the home's documentation related to the Continence Care Program there was no annual evaluation of the residents' satisfaction with the range of continence care products, with no consultation with the residents, substitute decision-makers or direct care staff. The PSWs, RN and RPNs interviewed confirmed they did not participate in an annual evaluation of the home's continence care products. Residents and substitute decision-makers interviewed confirmed they had not been asked to participate in an evaluation of the home's continence care products. The Resident Care Coordinator and the DOC confirmed there was no annual evaluation of the residents' satisfaction with the range of continence care products, and no consultation with the residents, substitute decision-makers and direct care staff. [s. 51. (1) 5.]

2. The licensee did not ensure that, (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #001, #012 and #031 were incontinent and based on the clinical records reviewed for each resident, they had never received an assessment that included identification of causal factors, patterns, type of incontinence and/or if there was any potential to restore function with specific interventions. The RNs and RPNs interviewed were not aware of what clinically appropriate assessment instrument they used at the home, and stated they only conducting continence assessments on new admissions. The RCC and DOC confirmed the home used the continence assessment tool supplied by the home's vendor. They stated that staff were expected to conduct a continence assessment within seven days of a resident's admission, when there was a change to a residents health status, and quarterly.

Although resident #001 had a change in health status, a continence assessment was not completed. In addition, there was no continence assessment that included identification of causal factors, patterns, type of incontinence and/or if there was any potential to restore function with specific interventions on a quarterly or annual basis for resident #001, #012 or #031. The RNs, RPNs, RCC and DOC confirmed no continence assessments using the home's clinically appropriate assessment instrument had been conducted for resident #001, #012 and #031. [s. 51. (2) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the continence care and bowel management program must, at a minimum, provide for (1)5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated; and 51.(2)(a) that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.***

---

**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the following were developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

3. Resident monitoring and internal reporting protocols.

4. Protocols for the referral of residents to specialized resources where required.

Upon inspection of the home's approaches to responsive behaviours the LTC Inspector was unable to locate written approaches to care, written strategies, resident monitoring and internal reporting protocols, or protocols for the referral of residents to specialized resources in the home. The DOC confirmed that the home had not developed these written approaches to care, strategies or protocols to meet the needs of residents exhibiting responsive behaviours and those affected by them. [s. 53. (1)]

2. The licensee failed to ensure that the responsive behaviour program was evaluated annually. Upon inspection of the home's responsive behaviour program, no documentation was available regarding the home's evaluation of matters referred to in subsection 53(1). The DOC confirmed that the home had not evaluated approaches to care, strategies or protocols used to address responsive behaviours in the home. [s. 53. (3) (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 following are developed to meet the needs of residents with responsive behaviours: 53(1)1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other; 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours; 3. Resident monitoring and internal reporting protocols; 4. Protocols for the referral of residents to specialized resources where required; and to ensure r.53.(3)(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.***

---

**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes**
**Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:**
**1. A change of 5 per cent of body weight, or more, over one month.**
**2. A change of 7.5 per cent of body weight, or more, over three months.**
**3. A change of 10 per cent of body weight, or more, over 6 months.**
**4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

1. A change of 5 per cent body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over six months.

A) Resident #013 had a significant change in body weight of greater than 7.5 per cent over three months documented in 2014. Clinical records identified that no interdisciplinary assessment regarding the change was conducted. Registered nursing staff confirmed that the resident did not receive an interdisciplinary assessment.

B) Resident #013 had a significant change in body weight of greater than 10 per cent over six months documented in 2014. Clinical records identified that no interdisciplinary assessment regarding the change was conducted. Registered nursing staff confirmed that the resident did not receive an interdisciplinary assessment.

C) Resident #035 had a significant change on body weight of greater than five per cent over one month, 7.5 per cent over three months,and 10 percent over six months in 2014; clinical records identified that no interdisciplinary assessment regarding the change was conducted. Registered nursing staff confirmed that the resident did not receive an interdisciplinary assessment. [s. 69.]

***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 with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:***
***1. A change of 5 per cent of body weight, or more, over one month;***
***2. A change of 7.5 per cent of body weight, or more, over three months;***
***3. A change of 10 per cent of body weight, or more, over 6 months; and***
***4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.***

---

**WN #17: 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:**
**6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,**
**(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).**

**s. 73. (2) The licensee shall ensure that,**
**(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that foods were stored and served at temperatures that were safe and palatable to residents.

A) During interview, the Food Service Manager stated that dietary staff were to record food temperatures on the production sheet in the kitchen prior to meal service, and on the temperature record form in the servery just before meal service. The temperature

record form used by dietary staff in the servery indicated that hot foods were to be served and held at 60 degrees Celcius or higher, and cold foods at 4 degrees Celcius or lower for the meal service. The Nutrition Manager confirmed this expectation.

i) On August 28, 2014, during supper meal service, the temperature record form in the servery was reviewed and no temperatures were recorded for the meal. The Cook serving confirmed they did not measure food temperatures in the servery prior to meal service.

ii) Seven out of eleven meal temperature records were incomplete on the production sheets from August 24 to August 28, 2014.

iii) Six out of twelve food temperature records were incomplete on the food temperature record logs from August 24 to August 28, 2014.

B) On August 25, 2014, resident #025 stated that food was not always served at the proper temperature, and at times, if they weren't served first, their food would not be hot enough.

C) On August 28, 2014, during supper meal service, eleven foods were tested for food temperatures. Eight hot foods were found below 60 degrees Celcius, and one cold food was above 4 degrees Celcius. Dietary staff continued to serve food found below temperature to residents.

i) Regular texture brussel sprouts were probed at 55.7 degrees Celcius, minced 47 degrees Celcius, and puree 37 degrees Celcius.

ii) Regular texture beef steakette was probed at 58.2 degrees Celcius, minced 49 degrees Celcius, and puree 38 degrees Celcius.

iii) Regular texture ham and pineapple was probed at 56 degrees Celcius.

iv) Puree bread was probed at 22.8 degrees Celcius.

D) The home's employment record for the Cook serving supper on August 28, 2014 contained a letter to the Cook dated October 15, 2014, requesting that they "ensure all cooked items are checked to ensure proper temperatures". [s. 73. (1) 6.]

2. The licensee failed to ensure that no person simultaneously assisted more than two

residents who needed total assistance with eating or drinking.

The plans of care for residents #031, #040, and #401 indicated that they were to receive total assistance with eating and drinking.

A) On August 22, 2014, during lunch meal service, a PSW was observed providing total assistance to residents #031 and #040 with their meals. The PSW then moved around the table and began providing total assistance to resident #401. The PSW confirmed that they were assisting all three residents, and that each resident required total assistance.

B) On August 28, 2014, during supper meal service, a PSW was observed providing total assistance to residents #031, #040 and #401 with their meals. The PSW confirmed that they were assisting all three residents, and that each resident required total assistance.

C) On August 29, 2014, during lunch service, a registered staff was observed providing total assistance to residents #031, #040, #110, and #401 with their meals. The registered staff stated that they were assisting all four residents with their meal, and that all four had plans of care to receive full assistance with meals. [s. 73. (2) (a)]

3. The licensee failed to ensure that no resident who required full assistance with eating or drinking were served a meal until someone else was available to provide the assistance required by the resident.

A) On August 29, 2014, during lunch meal service, at 1215 hours, a PSW began feeding resident #031 soup, until another staff directed the PSW to serve meals. The PSW left the resident, and resident #031 did not receive assistance with their meal until 1225 hours by another staff member. Registered staff confirmed resident #031 required full assistance with eating and drinking. [s. 73. (2) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents; and 73. (2)(a) that no person simultaneously assists more than two residents who need total assistance with eating or drinking, to be implemented voluntarily.***

---

**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation**
**Every licensee of a long-term care home shall ensure,**
**(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;**
**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;**
**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**
**(d) that the changes and improvements under clause (b) are promptly implemented; and**
**(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect or residents, and what changes and improvements were required to prevent further occurrences.

The home was unable to provide documentation of any evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents. The DOC and the Administrator confirmed that the home had not conducted an evaluation of the home's policy to promote zero tolerance of abuse and neglect of residents at least once per year. [s. 99. (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 that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.***

---

**WN #19: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).**

**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).**

**s. 101. (3) The licensee shall ensure that,**
**(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).**
**(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).**
**(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the verbal complaint made to a staff member concerning the missing clothing and personal items for resident #004 was dealt with as follows: 1. The complaint was to be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint.

Resident #004 had personal items and clothing missing as reported by the Power of

Attorney (POA). The staff did not know if they had a complaint policy and procedure, and confirmed they had no training regarding the Complaints process in the home. The PSWs, RPN and RN confirmed that they had not notified the Resident Care Coordinator or the Director of Care (DOC) of the POA's complaint. The DOC was not aware of the missing clothing and personal items for resident #004. The DOC confirmed the staff had not notified her of the POA's complaint. The POA reported her concerns to the staff that were on duty at the time, and the POA was never informed of the investigation, or receive a written response of the outcome. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(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
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

A) On August 25, 2014, resident #038 stated that they had complained to the DOC approximately two months earlier regarding feeling rushed and poorly cared for by a staff member while receiving care. An interview with the DOC indicated that the DOC investigated the complaint but could not provide documentation to support their investigation.

B) On August 28, 2014, residents #020, #300, #310 informed the LTC Inspector that they were afraid of resident #024 when this resident entered their room during the past six months. These three residents stated that they had complained to the DOC regarding their fears and concerns. The DOC confirmed that the residents had approached her with their complaints.

The DOC confirmed that the issue was not fully resolved and a record was not kept in the home that included the nature of these complaints, the date the complaints were received, the type of action taken to resolve the complaints, the final resolutions, or response dates. [s. 101. (2)]

3. The licensee failed to ensure that a documented record of complaints was reviewed and analyzed at least quarterly, the results of a review and analysis contributed to

determining what improvements were required in the home, and that a written record was kept in the home of each review and of the improvements made. The DOC confirmed that complaints were not reviewed and analyzed quarterly. The DOC could not provide LTC Inspectors with documented records of review and analysis of complaints or a written record of each review and of improvements made if there were any. [s. 101. (3)]

***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 written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately; r.101(2) that that a documented record is kept in the home that includes,***
***(a) the nature of each verbal or written complaint;***
***(b) the date the complaint was received;***
***(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;***
***(d) the final resolution, if any;***
***(e) every date on which any response was provided to the complainant and a description of the response; and***
***(f) any response made in turn by the complainant;***
***and 101.(3) that,***
***(a) the documented record is reviewed and analyzed for trends at least quarterly;***
***(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and***
***(c) a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.***

---

**WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that with respect to restraining a resident by a physical device that staff applied the device in accordance with manufactures instructions, in relation to the following:

A) On August 22, 2014 at 1115 hrs, resident #040 was noted to be sitting in a wheelchair with a front fastening seat belt applied. There was a four inch gap between the resident's body and the seat belt. An RPN and RN confirmed the seat belt was loose, and stated they were unaware of the manufactures specifications for application of the belt. The Director of Care stated the home had no instructions on how to apply the seat belt according to manufactures specifications.(585)

B) On August 21, 2014 at 1610hrs resident #015 was noted to be sitting in a tilted wheelchair with a front fastening seat belt applied. It was noted that there was a six inch gap between the resident's body and the seat belt. The RCC confirmed that the seat belt was not applied according to manufactures directions. [s. 110. (1) 1.]

2. The licensee failed to ensure that where a resident was being restrained by a physical device, the staff only apply physical device that had been ordered or approved by the physician or registered nurse in the extended class, in relation to the following:

A) On August 21, 2014 at 1610hrs resident #015 was noted to be sitting in a tilted wheelchair with a front fastening seat belt applied. Staff and clinical documentation confirmed that the seat belt had not been ordered or approved by the physician or registered nurse in the extended class.

B) On August 22, 2014 at 1115hrs, resident #040 was noted to be sitting in a wheelchair with a front fastening seat belt applied. Staff and clinical documentation confirmed that the seat belt had not been ordered or approved by the physician or registered nurse in the extended class. [s. 110. (2) 1.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions; and r.110(2)1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.***

---

**WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program**

**Specifically failed to comply with the following:**

**s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).**

**Findings/Faits saillants :**

1. The licensee did not ensure that, at least annually, the training and orientation program was evaluated and updated, in relation to the following: [216(2)]

The DOC confirmed that the training and orientation program was not evaluated and updated in 2013. [s. 216. (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, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.***

---

**WN #22: 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. (2) The licensee shall ensure,**
**(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).**

**s. 229. (2) The licensee shall ensure,**
**(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).**

**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. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).**

**Findings/Faits saillants :**

1. The licensee failed to ensure, (d) that the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

In reviewing the home's Infection Prevention and Control Program (IPAC)and the Infection Prevention and Control Committee minutes, there was no annual evaluation of the program in accordance with evidence-based practices, or in accordance with

prevailing practices. The Director of Care (DOC) and the Resident Care Coordinator who are the home's designated IPAC leads, both confirmed that the home did not conduct an annual evaluation of the Infection Prevention and Control program. [s. 229. (2) (d)]

2. The licensee failed to ensure, (e) that a written record was kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

In reviewing the home's Infection Prevention and Control program (IPAC) there was no written record of an annual evaluation. The DOC and the Resident Care Coordinator are the designated co-leads for the program and both confirmed the home did not maintain records of any annual evaluation of the IPAC program. [s. 229. (2) (e)]

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

On August 29, 2014, during the lunch meal service, a PSW was observed clearing dirty dishes from tables. The PSW then continued to serve food to residents, clear dishes, and serve food through out the meal and did not wash or sanitize their hands. The PSW stated they were only told to wash hands before the meal. The DOC stated that the home's expectation was for staff to wash or sanitize their hands between clearing dishes and serving meals. The home's policy "Hand Hygiene", last revised February 2014, stated that "hands should be washed before handling and serving food", and "after situations or procedures in which contamination of hands is likely" (585). [s. 229. (4)]

4. The licensee failed to ensure that the information gathered under subsection (5) was analyzed and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

When reviewing the home's information that was gathered on every shift regarding resident infections, the registered staff were not aware if the information was analyzed and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks. Registered staff stated the shift reports were reviewed at change of shift among the team and once completed after twenty four hours the reports were filed. The staff were not aware if anyone else reviewed from an

infection, prevention and control perspective. The DOC confirmed that she and the co-lead for IPAC reviewed the shift reports and determined if any actions were required, however they did not analyze and review monthly. [s. 229. (6)]

***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 (d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; (e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented; and 229( 6) that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks, to be implemented voluntarily.***

---

**WN #23: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

On August 22, 2014, a stove in the activity room was found unsecured and fully functional upon turning the knob that activated the stove. Recreation staff stated the activity room door was always opened and unlocked. The DOC confirmed that residents had unsupervised access to the room during the day, and no mechanism was in place to prevent residents from turning the stove on. [s. 5.]

---

**WN #24: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.**

**Specifically failed to comply with the following:**

**s. 29. (1) Every licensee of a long-term care home,**
**(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).**
**(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the policy to minimize the restraining of residents was complied with in relation to the following: [29 (1) (b)]. Staff in the home did not comply with the home's policy [Restraint Policy] identified as subsection 4.1.3 and last reviewed in June 2012.

A) This policy directed that annual education on the minimal restraint program was to be offered. The home did not comply with this direction when the DOC confirmed that annual training was not provided to staff who provided direct care to residents in 2013.

B) This policy directed staff to assess the resident and the issue/risk that was causing the restraint to be considered.

i) Staff did not comply with this direction when on August 21, 2014 resident #015 was noted sitting in a wheelchair with a front fastening seat belt applied and the clinical documentation indicated there was not an assessment of this resident.

ii) Staff also did not comply with this direction when on August 22, 2014 resident #040 was noted to be sitting in a specialized chair with a front fastening seat belt applied and clinical documentation indicated there was not an assessment of this resident.

C) This policy directed staff to obtain an order from the physician for the specific type of restraint to be used. Staff did not comply with this direction when review of residents #015 and #040's health records indicated that an order was not found for the specific types of restraints being used for these residents. [s. 29. (1) (b)]

---

**WN #25: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that 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.

Review of the home's documentation and minutes of the Family Council meetings in 2013 and 2014, indicated that there was no written responses within ten days to any concerns or recommendations from the Family Council. After interviewing the DOC, it was confirmed that the home had not formally responded in writing within ten days to the Family Council related to concerns or recommendations. Also, after interviewing the Chair of Family Council and a member of the committee, it was confirmed that no written response has been received within ten days of the home being notified of any concerns or recommendations brought forward by the Family Council. [s. 60. (2)]

---

**WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program**

**Specifically failed to comply with the following:**

**s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,**
**(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).**
**(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).**
**(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).**
**(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).**
**(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).**
**(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the recreation program included the provision of supplies and appropriate equipment for the program. Regarding the purchase of supplies for the recreation program, the Residents' Council meeting minutes stated the following:

i) On April 25, 2014: "[staff] asked if the Recreation Staff take a sum of money from the Resident Council Fund for purchasing decorations for upcoming holidays and socials" and "The Council approved the purchase decorations. $200 allotted"
ii) On June 20, 2014: "$100 had gone to Pub supplies and $50 went towards Bingo money."

During interview on August 27, 2014, the Recreation Program Manager stated that expenses for resident activities was high and they thought that the Residents' Council "might be able to help out". They confirmed that the recreation supplies purchased with funds from the Residents' council should have been purchased by the home. [s. 65. (2) (a)]

---

**WN #27: The Licensee has failed to comply with LTCHA, 2007, s. 67. s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.**

**Findings/Faits saillants :**

1. The licensee failed to consult regularly with the Family Council, at least every three months.

The documentation from the home and the Family Council meeting minutes from 2013 and 2014 did not reflect any consultation by the home with the Family Council at least every three months. The Family Council Assistant and the DOC confirmed they were not aware of the home consulting regularly with the Family Council, at least every three months. The Chair and member of the Family Council also confirmed that the home did not regularly consult with Family Council, at least every three months, and were not aware that the home should have been consulting with them. [s. 67.]

---

**WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following:**

**s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that foods were prepared and served using methods to preserve appearance and food quality.

A) On August 29, 2014, during lunch meal service, puree bread was on the menu. The bread was observed pooling out on the plates served to residents, with a nectar thick consistency. The cook confirmed they prepared the puree bread, and the texture was not thick enough as to what was expected. (585) [s. 72. (3) (a)]

---

**WN #29: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

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

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that the advice of the Residents' Council was sought in developing and carrying out the Satisfaction Survey. Residents' Council meeting minutes were reviewed for meetings held between January 31, 2013 and August 20, 2014. No minute entries were found that indicated that Residents' Council's advice was sought on the development of the home's 2013 Satisfaction Survey. Interview with the president of the Residents' Council and with the Administrator confirmed that the home had not consulted Residents' Council on the development of the 2013 Satisfaction Survey. [s. 85. (3)]

2. The licensee failed to ensure that the satisfaction survey results were documented and made available to the Family Council.

In reviewing the home's documentation and the Family Council meeting minutes, there was no documentation of the Satisfaction Survey results. The DOC and Family Council Assistant were not aware if the documented Satisfaction Survey results were made available to the Family Council. The Chair of the Family Council confirmed that the Administrator did present the results of the Satisfaction Survey, however the documented results were not made available to the Family Council. [s. 85. (4) (a)]

---

**WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply**
**Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:**
**1. All areas where drugs are stored shall be kept locked at all times, when not in use.**
**2. Access to these areas shall be restricted to,**
**i. persons who may dispense, prescribe or administer drugs in the home, and**
**ii. the Administrator.**
**3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all areas where drugs were stored was kept locked at all times when not in use, in relation to the following: [130(1)].

A) On August 26, 2014 at 0940 hours in the East wing of the home the RN was observed leaving the medication cart to provide care to a resident out of sight of the medication cart. When the cart was checked it was unlocked and accessible to residents, visitors and other staff in the hallway. The RN confirmed she forgot to lock the medication cart and knows she is supposed to lock the cart when not in use. (129)

B) On August 21, 2013 at 1115hrs, the medication administration room door was noted to be open and the supply of medications unsecured. The registered staff member was not in the vicinity of the medication room and non-registered staff, residents and visitors had access to this room. A registered nurse confirmed that the medication room had been left open and unsecured. [s. 130. 1.]

---

**WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check**

**Specifically failed to comply with the following:**

**s. 215. (4) The licensee shall require that the staff member or volunteer provide the licensee with a signed declaration disclosing the following with respect to the period since the date the person's last criminal reference check under subsection (2) was conducted:**
**1. Every offence with which the person has been charged under the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada) and the outcome of the charge. O. Reg. 79/10, s. 215 (4).**
**2. Every order of a judge or justice of the peace made against the person in respect of an offence under the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), including a peace bond, probation order, prohibition order or warrant. O. Reg. 79/10, s. 215 (4).**
**3. Every restraining order made against the person under the Family Law Act or the Children's Law Reform Act. O. Reg. 79/10, s. 215 (4).**
**4. Every offence of which the person has been convicted under the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada). O. Reg. 79/10, s. 215 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a staff member provided the licensee with a signed declaration that the requirements regarding their criminal reference check under subsection (2) was complied with. The LTC Inspector reviewed a staff record for compliance of Regulation 215(2) and could not locate the criminal reference check. The staff who managed these files confirmed that the criminal reference check was not included in the staff member's file. The DOC stated that the home could not locate the criminal reference check and that the staff person indicated that they had submitted it. The home could not verify that the staff person had submitted their criminal reference check prior to their hire date in 2014. [s. 215. (4)]

---

**WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans**

**Specifically failed to comply with the following:**

**s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:**
**1. Dealing with,**
**i. fires,**
**ii. community disasters,**
**iii. violent outbursts,**
**iv. bomb threats,**
**v. medical emergencies,**
**vi. chemical spills,**
**vii. situations involving a missing resident, and**
**viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that emergency plans provided for vii) loss of one or more essential services including loss of the home's resident-staff communication and response system.

On August 19, 2014 staff were unable to locate a back up paging device when asked. The DOC provided the LTC Inspector with a paging device that did not activate when triggered by bed and washroom call stations in rooms 2116, 2117, 2120, 2124, 2126, 2127, 2128, and 2130. The Administrator stated that the home did not have any mechanisms that residents could use other than the current poorly functioning system to alert staff to their needs.

Between August 19 and 29, 2014, inspectors observed the home's resident-staff communication and response system to be in disrepair. The home's Administrator, Administrative Assistant and the DOC confirmed this. The Administrator indicated that the home did not have any mechanisms that residents could use other than the current poorly functioning system to alert staff to their needs.

When asked about the home's emergency plans in the event that the resident-staff communication and response system was lost, the Administrator stated that the home's emergency plan did not include a policy or contingencies for the resident-staff communication and response system as an essential service if the service was lost. [s. 230. (4) 1. viii.]

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 prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 22 day of January 2015 (A2)

| Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs |
| --- |
| |

Original report signed by the inspector.

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Amended Public Copy/Copie modifiée du public de permis

**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** THERESA MCMILLAN (526) - (A2)

**Inspection No. / No de l'inspection :** 2014_265526_0018 (A2)

**Appeal/Dir# / Appel/Dir#:**

**Log No. / Registre no. :** H-001101-14 (A2)

**Type of Inspection / Genre d'inspection:** Resident Quality Inspection

**Report Date(s) / Date(s) du Rapport :** Jan 22, 2015;(A2)

**Licensee / Titulaire de permis :** BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive, Georgetown, ON, L7G-2B8

**LTC Home / Foyer de SLD :** BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive, Georgetown, ON, L7G-2B8

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** Dan Oettinger

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

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

---

To BENNETT HEALTH CARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

---

**Order # / Ordre no :** 901

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

**Order / Ordre :**

The licensee is to immediately ensure that staff respond when resident-staff communication and response system is triggered.

**Grounds / Motifs :**

1. On August 19 and 20, 2014 the resident-staff communication and response systemwas not fully operational. Residents in the home were at risk for not having staff respond to their care and safety needs when it was identified that the resident-staff communication and response system was not fully operational.

The home's resident-staff communication and response system included a paging device that, when activated, clearly indicated to staff where the signal was coming from. The system failed to alert staff on eight out of ten occasions when the

resident-staff communication and response system was triggered.

A) On August 19, 2014, at 1400 hours the inspector triggered the resident-staff communication and response system at both the bed station and the washroom station for residents #029 in room 2033 and #032 in room 2037. The Personal Support Workers (PSWs) providing care to residents #029 and #032 confirmed that their paging devices were not activated when the resident's staff communication response system was triggered.

B) Staff confirmed that on August 19, 2014 they were aware that their paging devise was non functional, and continued to carry the pager for the remainder of their shift.

C) On August 19, 2014, at 1400 hours the inspector triggered the resident staff communication and response system at both the bed station and the washroom station for residents #028 [redacted] and #031 [redacted]. PSW assigned to resident #028 and #031 reported to the inspector that they were not carrying their paging device. This PSW indicated that when they arrived at work, a paging device was not available for their use during their shift.

D) On August 20, 2014, at 1030 hours the inspector triggered the resident staff communication and response system for the resident washroom station for resident #032 [redacted]. The PSW assigned to this resident confirmed that their paging device was not activated when triggered.

E) On August 20, 2014, at 1015 hours, inspector triggered the resident staff communication and response system for resident #022 [redacted]. The PSW assigned to this resident confirmed that their paging device was not activated when triggered. One hour and fifteen minutes later, the Administrator's Assistant confirmed that the paging device remained non functional.

F) On August 20, 2014 a PSW confirmed to the inspector that the non functioning of the paging devices was an ongoing issue in the home.

2. Previously identified on October 28, 2013 as a VPC. Previously identified on July 02, 2014, as a Compliance Order. (129) (585) (526)

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

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

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

Aug 20, 2014

---

**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2014_306510_0014, CO #003;

**Pursuant to / Aux termes de :**

LTCHA, 2007, 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

**Order / Ordre :**

The licensee shall demonstrate that residents' rights to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs are fully respected.

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

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

**Grounds / Motifs :**

1. The licensee failed to ensure that residents' rights to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs was fully respected.

Between August 22 and 28, 2014 resident #038, #020, #300, and #310 informed the Long Term Care (LTC) Inspector that resident #024 would repeatedly wander into their rooms both when they were awake and asleep. They stated that if they asked resident #024 to leave, the resident was verbally abusive and made gestures toward them that frightened them. These residents had complained to the home about their fears. Management of resident #024's responsive behaviours included the use of door guards and gentle persuasion techniques if the resident were to wander into a co resident's room. Residents stated that despite these measures, resident #024 continued to [redacted] they continued to feel afraid.
demonstrate responsive behaviours. KW

Registered staff, the DOC and the Administrator confirmed that resident #024 continued to wander into co-residents' rooms and that some residents were afraid of [redacted] despite measures in effect. They stated that they had not considered the needs of the residents who were victims of the responsive behaviours and had not addressed their fears, concerns and need for protection. [s. 3. (1) 4.] (526)

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

Nov 30, 2014

**Linked to Existing Order / Lien vers ordre existant:** 2014_306510_0014, CO #001;

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(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).

**Order / Ordre :**

(A2)
The licensee shall perform the following:

A) Demonstrate that the home s resident-staff communication and response system is reliable and consistently functional.

B) Staff shall carry their paging devices when responsible for resident care

C) Staff shall be familiar with and trained in the use of the home s resident-staff communication response system

D) Develop policies and procedures, regarding but not limited to, the staff s use of the resident-staff communication and response system; maintenance and repair of the system, frequency and content of audits, and who is responsible for conducting audits, ensuring repairs have been completed and that the system is functional.

E) Conduct scheduled and as needed audits on the resident-staff communication and response system and maintain records of the audits that include the person responsible, the frequency of audits, the status of the system at each call station and each paging device and whether repairs are needed.

F) The home shall, in a timely manner, repair or replace components of the system that are in dis repair and prepare written documentation of the status of repair and when the repair has been completed.

G) Prepare and implement policies regarding contingencies for potential failure of the resident-staff communication and response system as an essential service.

**Grounds / Motifs :**

1. The licensee failed to ensure that the home was equipped with a functioning resident-staff communication and response system. Residents in the home were at risk for not having staff respond to their care and safety needs when it was identified on August 19 and 20, 2014 that the resident-staff communication and response system was not operational.

The home's resident-staff communication and response system included a paging device that, when activated, clearly indicated to staff where the signal was coming from. The system failed to alert staff on eight out of ten occasions when the resident-staff communication and response system was triggered.

A) On August 19, 2014, at 1400 hours the Long Term Care (LTC) Inspector triggered the resident-staff communication and response system at both the bed station and the washroom station for residents #029 and #032. The Personal Support Workers (PSWs) providing care to residents #029 and #032 confirmed that their paging devices were not activated when the resident's staff communication response system was triggered.

B) Staff confirmed that on August 19, 2014 they were aware that their paging devise was non functional, and continued to carry the pager for the remainder of their shift.

C) On August 19, 2014, at 1400 hours the inspector triggered the resident staff communication and response system at both the bed station and the washroom station for residents #028 and #031. PSW assigned to resident #028 and #031 reported to the inspector that they were not carrying their paging device. This PSW indicated that when they arrived at work, a paging device was not available for their use during their shift.

D) On August 20, 2014, at 1030 hours the inspector triggered the resident staff communication and response system for the resident washroom station for resident #032. The PSW assigned to this resident confirmed that their paging device was not activated when triggered.

E) On August 20, 2014, at 1015 hours, inspector triggered the resident staff communication and response system for resident #022. The PSW assigned to this resident confirmed that their paging device was not activated when triggered. The Administrator's Assistant confirmed that the paging device remained non functional.

F) On August 20, 2014 a PSW confirmed to the inspector that the non functioning of the paging devices was an ongoing issue in the home.

On August 20, 2014 an Immediate Compliance Order (#901) was issued that the licensee immediately ensure that staff responded when the resident-staff

communication and response system was activated. The Compliance Order was complied with when the home instituted a temporary plan to add an additional staff person to the schedule. This staff person was to monitor the resident-staff communication and response system to ensure that staff responded when the system was activated.

Beginning on August 20, 2014, and in response to the Immediate Compliance Order # 901, an additional staff member was present for all shifts to monitor that the call bells were being answered.

The home's resident-staff communication and response system continued to malfunction for the remainder of the inspection until August 29, 2014.

A) Between August 20 and 29, 2014, the DOC, Administrative Assistant (AA) and staff confirmed that the system was unreliable.

B) On August 22, 2014, the washroom station in room 2043 was triggered and did not activate the paging device for non registered staff.

C) On August 22, 2014, the DOC confirmed that the home's resident-staff communication and response system vendor stated that they did not have parts to repair the system.

D) Between Friday August 22, 2014 and Thursday August 28, 2014, the home had instituted an audit of the resident-staff communication and response system where staff were required to trigger the system at all resident bed and washroom stations during each shift. These records indicated that pagers were activated inconsistently between August 22 and 28, 2014 for bed and washroom stations in rooms: 2111, 2137A, 2106, 2021, 2023A, 2023B, 2031A, and bed station for 2045B, 2048, 2049. The DOC, and AA confirmed that the call bells were functioning inconsistently between these dates and at the time inspectors exited the home.

E) On August 29, 2014, the Administrative Assistant stated that call stations in room 2127 functioned intermittently despite the fact that staff found that they were functioning during the audit.

The Administrator, the AA and the DOC confirmed that the home was aware that the resident-staff communication and response system was not reliable and did not

indicate, when activated, where the signal was coming from.

This non compliance was previously identified on October 28, 2013 as a VPC; on July 02, 2014, as a Compliance Order to submit and comply with a plan by August 08, 2014. The home's plan submitted to the Long Term Care (LTC) Insepctor indicated that many actions related to the Compliance Order had been completed such as staff education about mandatory requirements for the use of the paging device, the implementation of a process to ensure that staff carry their pagers, and how to monitor the system if it was found to be ineffective. However, the findings as noted above did not coincide with the implementation of the plan as laid out.

On August 19, 2014 the home was issued an Immediate Compliance Order to immediately ensure that staff responded when the resident-staff communication and response system was triggered. [s. 17. (1) (f)] (526)

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

Feb 27, 2015(A2)

---

**Order # /**
**Ordre no :** 003

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

**Order / Ordre :**

(A2)
The licensee shall develop and implement procedures and interventions to assist residents who are at risk of harm or who were harmed as a result of a resident's behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

The licensee shall demonstrate the following:
a) Assess the effects of responsive behaviours on residents at risk or who have been harmed by other residents with responsive behaviours
b) Document the assessment in residents health records
c) Ensure that there is a written plan of care setting out the planned care for residents at risk of harm or who have been harmed by a resident with responsive behaviours, the goals the care is intended to achieve and clear directions to staff and others who provided direct care to residents
d) Implement the plan of care as designated in the plan
e) Evaluate the effectiveness of the plan of care in achieving the goals as set out in the plan of care in assisting residents who are at risk or who have been harmed by residents exhibiting responsive behaviours

**Grounds / Motifs :**

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents who were at risk of harm or who were harmed as a result of a resident's behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

A) Review of resident #024's Resident Assessment Instrument Minimum Data Set (RAI MDS) and associated Resident Assessment Protocol (RAP) completed in 2014 indicated that the resident "exhibited wandering into other residents' rooms", and "may become verbally and physically abusive (may strike out when asked for [their] cooperation with care)". Interview with registered staff and review of the resident's health record indicated that the resident's responsive behaviours had worsened since the previous (RAI MDS quarterly assessment.

Interviews with registered and non registered staff, the DOC and the Administrator confirmed that the resident exhibited wandering into other residents' rooms, verbal and physical aggression and gestures that intimidated and frightened other residents. Medical consultation by the psychogeriatric outreach team that occurred one month prior to the RAI MDS assessment noted above included recommendations on how to manage resident #024's responsive behaviours in relation to other residents. The Behavioural Supports Ontario (BSO) staff and the DOC confirmed that the recommendations had not been followed. They confirmed that resident #024's plan of care did not address minimizing risk to harm of other residents in the home.

B) During an interview with the LTC Inspector on August 25, 2014, resident #038 reported that resident #024 frequently wandered into their room while they were getting dressed in the morning, and while they were sitting next to their bed in a wheelchair. When resident #038 told resident #024 to "get out", resident #024 formed a fist with their hand and stated "I'll get you out"; this frightened resident #038.

Resident #038 stated they had been complaining about their fear and upset to the staff for a six month time period. Resident #038 stated that the DOC and the Administrator instructed them to trigger the staff-resident communication response system (call bell) if the resident entered their room. Resident #038 stated that the call bell system was not functioning consistently, and due to their limited mobility, they may not be able to reach the 'call bell' to alert staff, or to get out of the room without becoming injured first; this had further contributed to their fear. Progress notes, non registered staff and the DOC confirmed that resident #038 called police on July 23, 2014 due to their concerns about resident #024.

C) On August 28, 2014, residents #020, #300, #310 informed the LTC Inspector that resident #024 would wander into their rooms during the past six months, was verbally

abusive and made gestures toward them that frightened them. They stated that after they had complained to the home about their fears, the resident continued to wander into their rooms and they continued to feel afraid.

The DOC and Administrator verified that they had not considered the harmful effects that resident #024's responsive behaviour was having on other residents living in the home. They confirmed that procedures and interventions currently in place did not assist residents who were at risk of harm or who were harmed as a result of a resident's behaviours. The risk of altercations and potentially harmful interactions between and among resident #024 and other residents in the home had not been minimized. [s. 55. (a)] (526)

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

Feb 27, 2015(A2)

---

**Order # /**
**Ordre no :** 004

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

**Linked to Existing Order /**
**Lien vers ordre existant:**

2014_306510_0014, CO #002;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

**Order / Ordre :**

The licensee shall:

A) Develop policies and procedures regarding the maintenance of all equipment, devices, assistive aids and positioning aids in the home to include processes for auditing, staff reporting, timely repair and monitoring the status of repairs underway.

B) Prepare a written schedule for regular auditing of the state of repair of all equipment, devices, assistive aids and positioning aids in the home specifying the frequency of the audits, who is responsible to conduct the audit, and equipment to be audited.

C) Conduct regularly scheduled audits of all equipment, devices, assistive aids and positioning aids in the home to ensure that disrepair is identified proactively and document the results of the audit.

D) Remove all equipment, devices, assistive aids and positioning aids that are in disrepair from resident care areas; inform staff of equipment that is in disrepair and not for resident use.

E) Repair equipment in disrepair in a timely manner and provide written documentation of items under repair, the status of the repairs, and when repairs have been completed; introduce equipment, devices, assistive aids and positioning aids back into circulation for resident use only upon full inspection that repairs have been completed.

F) Maintain all equipment, devices, assistive aids and positioning aids used by residents in the home in good repair, excluding the residents' personal aids or equipment.

**Grounds / Motifs :**

1. The licensee 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.

On August 20, 2014 the Administrator of the home and the Administrator's Assistant (AA) confirmed that they were jointly responsible for maintaining the home.

A) The Administator and the AA described the process of maintaining equipment, devices, assistive devices and positioning aids in the home as responsive and that the process did not consistently ensure that equipment was kept in good repair. The home relied on staff to identify broken equipment as they were using it, and to make an entry in the home's "Staff Maintenance Request" Log book. The AA described the process staff were to use when completing the log book and confirmed that the home did not maintain notes or procedures that ensured that equipment was in good repair.

The AA stated that that if a maintenance issue was not identified by staff, staff may continue to use the equipment, device, assistive aid and positioning aid without realizing that it was in poor repair.

Review of the home's maintenance log indicated that seven resident beds being used by residents in the home were noted as being in poor repair on the following dates;
i) room 2046 noted on July 4 and 8, 2014;
ii) room 2040 noted on July 6;
iii) room 2028 noted on July 16, 2014;
iv) room 2023 noted on July 21 and 27, 2014;
v) room 2129 noted on July 29, 2014;
vi) room 2105 noted on August 3 and 18, 2014; and
vii) room 2034 noted on August 26, 2014.

In each case, there was no entry in the Maintenance Log book that the issue had been resolved or completed and this was verified by the AA. In fact, the AA verified that the home did not routinely return to the maintenance issue to determine whether repairs and maintenance had been completed. Out of at least 275 maintenance issues entered into the maintenance log between November 1, 2013 and August 29, 2014, four had entries that the issue had been completed or resolved. [s. 90. (2) (b)] (526)

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

Mar 31, 2015(A2)

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

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

---

**Order # / Ordre no :** 005

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

**Order / Ordre :**

(A2)
Where bed rails are used, the licensee shall:

a) Assess the resident and evaluate his or her bed system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

b) Document the resident assessment and retain the assessment as a part of the resident s health record;

c) If the bed rail has a restraining effect, the bed rail is to be treated as a restraint and the relevant legislative requirements followed.

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

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

**Grounds / Motifs :**

1. The licensee failed to ensure that when bed rails were used the resident was assessed in accordance with evidenced-based practices to minimize risk to the resident: [15(1) (a)].

The DOC confirmed that when bed rails were used for residents #003, #031, #032, #038 and #400, that the residents were not assessed for the use of those bed rails. On August 25, 2014 the PSW providing care for resident #003 confirmed that the two quarter rails that were affixed to the resident's bed were used whenever the resident was in bed. On August 19, 2014 resident #031 was noted to be in bed with two quarter rails in the active position. On August 25, 2014 the PSW providing care for resident #032 confirmed that the two quarter rails affixed to the resident's bed were used whenever the resident was in bed. On August 25, 2014 the PSW providing care to resident #038 confirmed that the two quarter rails affixed to the resident's bed were used whenever the resident was in bed. On August 19, 2014 resident #400 was noted to be in bed with two quarter rails in the active position. [s. 15. (1) (a)] (129)

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

Feb 27, 2015(A2)

---

**Order # /**
**Ordre no :** 006

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

**Pursuant to / Aux termes de :**

LTCHA, 2007, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

**Order / Ordre :**

The licensee shall:

A) Prepare in writing: the content of training sessions, schedules and evidence that staff have attended training sessions.

B) Training and retraining all staff at the home according to legislative requirements, specifically, s.76 (Training) and O.Reg 216 to 222 inclusive (Training and Orientation) including but not limited to the following areas:

1. The Residents' Bill of Rights.
2. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
3. The duty under section 24 to make mandatory reports.
4. The protections afforded by section 26.
5. The long-term care home's policy to minimize the restraining of residents.
6. Infection prevention and control.
7. Abuse recognition and prevention.
8. Mental health issues, including caring for persons with dementia.
9. Management of behaviours and responsive behaviours
10. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
11. Skin and wound Care
12. Continence Care and Bowel Management
13. Any other areas provided for in the regulations.

**Grounds / Motifs :**

1. The licensee failed to ensure that the persons who had received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

A) Infection Prevention and Control (IPAC): When reviewing the IPAC staff training records regarding hand hygiene; modes of infection transmission; cleaning and disinfection practices; and the use of personal protective equipment, there were 43 out of a total of 93 staff in the home trained. In 2013 the total number of staff trained in infection prevention and control measures was 42, and in 2012 the total number of staff trained in infection prevention and control measures was 22. The DOC and the Resident Care Coordinator (RCC) as the co-leads for the IPAC Program confirmed that not all staff have been trained for infection prevention and control. (527)

B) Prevention of Abuse, Neglect and Retaliation: The licensee failed to ensure that all staff had received retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protections in accordance with O. Reg. 221(2). Five staff who were interviewed stated that they had not received annual training related to the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protections. Two staff stated that they had not received training in the past five years. The home was unable to provide documentation of the content of the retraining as described above or staff sign up sheets for this staff training. The DOC confirmed that the home had not ensured that all staff who provided direct care to residents had received retraining relating to the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protections annually. (526)

C) Minimizing of Restraints: The licensee did not ensure that all staff who provided direct care to residents received annual retraining in accordance with O.Reg. 79/10 219(1), in relation to the following: [76(7) (4)]. The Director of Care confirmed that staff who provided direct care to residents had not received retraining in relation to minimizing the restraining of residents and, where restraining was necessary how to do so in accordance with the Act and the regulations in 2013 because training was not offered. [s. 76. (4)]

2. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the following areas:

A) Skin and wound Care: In reviewing the home's training records there were no records for skin and wound care training in 2013. In 2014 there were five registered

staff and seventeen PSWs who attended training on January 8, 2014. The training was provided by the home's vendor of skin and wound care products and did not include training related to the Skin and Wound Care Program; the DOC and Resident Care Coordinator (RCC) confirmed this. One RN confirmed they had no training during the home's orientation as a new employee, and an RPN confirmed they had no Skin and Wound Care training in over one and a half years.

B) Continence Care: During review of the home's documentation related to the Continence Care Program, no records were found to support that annual training was provided to direct care providers. The PSWs, RNs, RPNs interviewed confirmed they had not received annual retraining related to the home's Continence Care Program. The RCC and the DOC also confirmed that direct care providers had not received annual retraining related to the home's Continence Care Program. [s. 76. (7) 6.] (526)

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

Dec 31, 2014

---

**Order # /**
**Ordre no :** 007

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

**Pursuant to / Aux termes de :**

LTCHA, 2007, s. 84. s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

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

**Order / Ordre :**

(A1)
The licensee shall:

A) Develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

B) Provide complete and documented evidence of the development and implementation of:

i) the quality improvement and utilization review system including the home s goals, objectives, policies, procedures and protocols; and

ii) development and implementation of improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents as specified in s. 84 and O. Reg 228.

**Grounds / Motifs :**

1. The licensee failed to develop and implement a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care, services, programs and goods provided to residents of the home.

The home's policy for "Quality Process" 1.2: 4.0 "Quality Indicators", 5.0 "Quality Audits", 6.0 "Quality Projects", 7.0 "Benchmarking", and 8.0 "Risk Management" last revised on August 1, 2014 directed staff in the implementation of the home's quality system. This included collecting, recording analyzing and evaluating data for quality indicators and conducting audits; reporting results to staff, teams and the Board; defining solutions to problems identified; taking steps to improve care; and risk management including staff education.

Between August 19 and 29, 2014 the quality improvement and utilization review system was noted to have the following deficiencies:

A) Compliance Orders: The following Compliance Orders issued on July 2, 2014 were not complied with as specified in the Orders by August 8, 2014 and at the time of this inspection:

i) #001 r. 17.(1) Resident-staff communication and response system; an Immediate Compliance Order #901 was issued during this inspection
ii) #002 r. 90.(2) Equipment properly maintained; and
iii) #003 s. 3. (1) Residents' Rights

B) Policies not developed: Policies and procedures for the following areas were not developed:

i) Complaints Procedure (s. 21)
ii) Responsive Behaviours (r. 53(1))
iii) Maintenance Services (r. 90)
iv) Emergency Plans (r. 230(4)viii)

C) Policies not complied with: Policies and procedures in the following areas were not complied with:

i) Infection Prevention and Control (r. 8.(b))
ii) Continence Care and Bowel Management (r. 8.(b))
iii) Skin and Wound Care (r. 8.(b))
iv) Measurement of Vital Signs (r. 8.(b))
v) Minimizing Restraints (r. 29(1)(b))
vi) Prevention of Abuse and Neglect (s. 20(1))

D) Evaluation: Program evaluations were not conducted for the following areas for at least the past two years:

i) Skin and Wound Care Programme (r. 30(1)3)
ii) Continence Care and Bowel Management (r. 30(1)3 and r. 51(1)5)
iii) Responsive Behaviours (r. 53(3)(b)
iv) Prevention of Abuse and Neglect (r. 99)
v) Dealing with Complaints (r. 101(3))
vi) Infection Prevention and control (r. 229(6))

E) Training: Retraining was not provided to staff in the home in the following areas:

i) Infection Prevention and Control
ii) Prevention of Abuse and Neglect
iii) Minimizing Restraints
iv) Skin and wound Care
v) Continence Care and Bowel Management

The Director of Care confirmed the above deficiencies in the home's quality improvement and utilization review system. She confirmed that policy development and implementation, program evaluation and staff training had not been consistently integrated on an ongoing basis into the home's operations.

The Administrator confirmed that the home could not provide data regarding the implementation of the home's quality program. He also confirmed that the home had not conducted audit reviews, discussed quality improvements with residents, family members or staff, and had not developed plans for improvements. [s. 84.] (526)

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

Mar 31, 2015(A2)

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director