Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 10, 2017	2016_512196_0015	022136-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.2) LP
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577), KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 29, 30, 31, September 1, 2, 6, 7, 8, 9, 12, 13, 14, 15 and 16, 2016.

The following intakes were inspected concurrently:

Critical Incident System (CIS): four intakes related to resident care; two intakes related to a missing resident; five intakes related to resident to resident abuse; one intake related to staff to resident abuse; two intakes related to a resident fall; two intakes related to resident behaviours.

Complaint: one intake related to resident care concerns and one intake related to staffing concerns.

Follow up: one intake related to a Compliance Order for plan of care.

During the inspection, the Inspectors conducted a walk through of resident care areas, observed staff to resident interactions and the provision of care and services to residents, reviewed submitted Critical Incident System (CIS) reports, reviewed various home policies and procedures, several employee files and resident health care records.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Acting Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Manager, Environmental Services Manager (ESM), Resident Assessment Instrument (RAI) Coordinator, Quality Care Coordinator, Quality Assistant, Housekeeping Aide, Activation Assistant residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Director in 2016, related to an incident of resident #016 elopement. At a later date, another CIS report was submitted to the Director related to second incident of resident #016 elopement.

The first incident, resident #016 went on a leave of absence with a friend and was to have returned hours later. The resident was later found by an outside agency and taken to the hospital.

The second incident, resident #016 went on a leave of absence with a friend and returned to the home hours later, by an outside agency.

During a record review of resident #016's health care records, Inspector #577 found a physician's order which indicated the resident had passes for a leave from the home.

During a review of resident's care plan, the Inspector identified a nursing focus related to elopement and the interventions indicated that resident #016 was not allowed to go out on leave of absences.

During an interview with the DOC, they confirmed with Inspector #577 that on both incident dates, resident #016 did leave the home for a leave of absence with a friend/responsible person. They further confirmed that the care plan was not clear, as the care plan document indicated that the resident was not allowed to go out on leave of absence and the physician's order indicated they could leave. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

During a family interview, resident #004's family member stated that their family member had a preference to engage in a particular activity and that staff did not assist the resident to engage in that activity.

During a record review of resident #004's progress notes, Inspector #577 found documentation dated Autumn 2015 which indicated that the resident's family member had requested their family member to engage in the particular activity. The documentation further indicated that the DOC would communicate this request to the recreational program department.

During a review of the resident's care plan related to recreation activities, the documentation revealed that the resident's interests included two specific activities and that staff were to provide the resident with appropriate opportunities to participate in programs as per their interests. The family member's request for the resident's participation in the particular activity was not included in the plan of care.

During an interview, the Recreation Manager #101 stated to Inspector #577 that they had

engaged resident #004 in the particular activity but due to staffing issues, the particular activity did not resume. [s. 6. (5)]

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

In the summer of 2016, a Critical Incident System (CIS) report was submitted to the Director for an incident. The mandatory report identified the category of "improper/incompetent treatment of a resident that results in harm or risk to a resident". According to the report, resident #025 had complained of a change in their physical condition early in the morning on a specific date, but was not transferred to the acute care hospital until after a physician's order for transfer was received hours later.

The health care records for resident #025 were reviewed by Inspector #196. The "Advance Directives" document signed by the resident identified that "if symptoms indicate, the resident would be transferred to an acute care hospital for treatment. Assessment would be made in the acute care hospital emergency department and a decision made whether to admit the resident or return him/her to the Extendicare facility. No cardiopulmonary resuscitation is requested and no admission to an acute care intensive care unit."

The progress notes documented on the date of the incident identified that the resident had complained of a change in their physical condition. Later that same day, another note identified continued change in the resident's physical condition and included that a message was left for the physician. Additional progress notes during the day shift continued to document the declining physical condition of resident #025. Later that day, several hours after the resident had first complained of a change in their physical condition, the resident was transferred to hospital.

During the inspection, Inspector #196 conducted an interview with the Director of Care (DOC) regarding the investigation into the improper care of the resident #025. The DOC reported that the investigation had not been conducted in entirety and interviews with some of the staff present on the day of the incident had not yet been done. In addition, they reported that the resident should have been sent to the hospital when symptoms had first appeared and staff should not have waited for a physician's order to send the resident to hospital. The DOC acknowledged to the Inspector, the plan of care, specifically, the advance directives as signed by the resident included transfer to acute care hospital based on their symptoms they were experiencing, and this was not done.

[s. 6. (7)]

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

A Critical Incident System (CIS) report was submitted to the Director on a specific date in the summer of 2016, related to a resident fall. The report indicated that resident #006 had experienced falls and one of the falls resulted in an injury. The report further indicated that the resident was not immediately assessed after the fall.

A review of the resident #006's current care plan did not indicate a recent fall or the injury they sustained.

During an interview with the RAI Coordinator #113, during the inspection, they confirmed with Inspector #577 that the current care plan did not reflect the residents' change of condition, which included a fall with an injury. [s. 6. (10) (b)]

5. Resident #013 was identified through stage one of the inspection for having had a fall on a specific date, in the summer of 2016.

The health care records for resident #013 were reviewed by Inspector #196 for information regarding falls. The progress notes identified an unwitnessed resident fall out of bed on the specific date in the summer of 2016. The current care plan identified under the focus of high risk for falls, the intervention of a fall prevention device, and additional interventions.

During the inspection, observations were made and the resident did not have a falls prevention device in place.

An interview was conducted with RPN #103 and they reported that resident #013 no longer used this falls prevention device. [s. 6. (10) (b)]

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 that ensures that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident; that ensures the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care; that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

During an interview in stage one of the Resident Quality Inspection, resident #007 reported to Inspector #577 that resident #004 scares them because they have displayed specific responsive behaviours. They further reported that resident #004 displayed specific responsive behaviours towards residents who cannot help themselves and the other residents get scared.

On a specific date, during the inspection, resident #004 approached Inspector #577 in a particular manner and displayed specific responsive behaviours. The resident proceeded to walk out into the hallway and Housekeeping Aide #116 brought the resident to their bathroom. The resident displayed specific responsive behaviours to the housekeeper. Ten minutes later, the Inspector observed resident #004 seated on a sofa in the television (tv) lounge, displaying specific responsive behaviours. A few minutes later, an unidentified PSW escorted the resident to their room while the resident was displaying specific responsive behaviours.

During an interview with PSW #117 they reported to Inspector #577 that resident #004's behaviours included specific responsive behaviours towards staff and residents. Staff were to verbally re-direct the resident and offer them snacks.

During an interview with PSW #110 they reported that resident #004's behaviour included specific responsive behaviours. Staff were to redirect the resident to their room and attempt to provide the resident with a particular item and complete two other interventions. They further reported that resident checks were initiated on a specific day and would end two days later.

During an interview with the outside agency PSW #118, they reported that resident #004 was referred to them approximately a year previous for various responsive behaviours. They further reported that the resident was discharged from their program approximately two months later because the suggested interventions had not been followed by staff. They further reported that the resident should have been re-referred for these current responsive behaviours.

During a record review of resident #004's progress notes, Inspector #577 found documented incidents of inappropriate behaviour towards staff and co-residents over an approximate ten month period. Inspector #577 conducted a record review of resident #004's current care plan and found the following interventions related to inappropriate behaviour, initiated at the start of that 10 month period:

- resident to be verbally prompted to deter from and discourage inappropriate behaviour; when seen doing so, resident would be informed that this inappropriate behaviour, when heard or seen
-if this intervention does not work, report to registered staff

During a record review of residents health care records, Inspector #577 found documentation for the Dementia Observation Scale (DOS) initiated during a ten day period in 2015. This DOS revealed episodes of specific responsive behaviour. The DOS, one year later, during a five day period, revealed responsive behaviour during the evening hours and episodes of specific responsive behaviour.

During an interview with the DOC, they reported to Inspector #577 that they were not aware that resident #004 had inappropriate behaviours over past approximate ten months and thought the behaviours were more recent. They further reported staff were monitoring the resident by initiating a recent DOS, altering the environment and staff were to dress the resident in a specific way. The DOC confirmed that staff should have referred the resident to the outside agency for further assessment when the resident started showing specific responsive behaviours at the beginning, approximately ten months previous.

During an interview with the DOC they further reported to Inspector #577 that the home's Resident Service Coordinator #119 was to have sent a referral to an outside agency approximately ten months previous and did not process the referral. [s. 53. (4) (c)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognize the resident's individuality and respects the resident's dignity.

On a particular day, during the inspection, Inspector #196 observed Housekeeping Aide #120 assist resident #026 with personal care while in the common area. Approximately eight other residents were present in the common area and would have been able to observe the personal care.

An interview was conducted with RPN #121 and they reported to the Inspector that the housekeeping staff should not assist residents with personal care and it should never be done in a common area where others may see.

Interview with DOC and they confirmed to the Inspector that the Housekeeping Aide was not to assist with personal care. In addition, the DOC reported that personal care was not to be completed in a common area of the home within view of other residents. [s. 3. (1) 1.]

2. A Critical Incident System (CIS) report was submitted to the Director in the summer of 2016 for an incident identified as staff to resident physical abuse. The report identified that resident #011 had been assisted roughly by PSW #115. The report also indicated that, after the incident, resident #011 avoided having PSW #115 assist with their care.

A review of the home's investigation file by Inspector #625 included interview notes from resident #011 and the staff that resident #011 had spoken to about the incident. The notes indicated that resident #011 stated PSW #115 was rough with them. The notes also indicated that, as a result of and following the incident, the resident began to wait for assistance, so that another staff member could assist them.

The investigation file also included a letter that indicated PSW #115 was issued disciplinary action related to this incident where they were in violation of resident's rights when they were rough with a resident while assisting with an aspect of care. The employee was given discipline.

A review of PSW #115's employee file identified a letter that indicated the employee was issued disciplinary action prior, as they had been in violation of resident's rights.

During an interview with Inspector #625, the Inspector asked resident #011 if they had ever been treated roughly by staff. The resident replied that they had informed the boss about it and provided specific details of the incident.

During an interview with Inspector #625, the DOC confirmed that PSW # 115 had been rough with resident #011 when assisting the resident with an aspect of their care as outlined in CIS report. [s. 3. (1) 1.]

3. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to be to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

On a particular day during the inspection, Inspector #625 observed resident #010 laying in their bed undressed from the waist down, from the hallway outside of the resident's room.

Inspector #625 spoke with the DOC several minutes following the initial observation, who then also observed resident #010 with no clothing on from the waist down, visible from the hallway outside of the resident's room. The DOC acknowledged that it was not appropriate for the resident to be exposed in that manner, to be seen from the hallway.

During an interview with Inspector #625 the DOC stated that resident #010 had been wearing pyjamas when PSW #114 left the resident alone in their washroom following

breakfast. The DOC stated that PSW #114 had confirmed that they did not close the door to the resident #010's bedroom when they left the resident alone in the washroom. The DOC stated that the resident dressed and undressed themselves but due to a medical condition, they did not know if the door to their room was open or shut. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures the following rights of residents are fully respected and promoted: 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; and every resident has the right to be to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and was

complied with.

A Critical Incident System (CIS) report was submitted to the Director on a specific date in the summer of 2016, related to a resident fall. The report indicated that resident #006 had experienced falls and one of the falls resulted in an injury. The report further indicated that the resident was not immediately assessed after the fall.

During the inspection, Inspector #577 reviewed the investigation notes related to the resident's second fall. The Inspector found that RPN #127 had not assessed the resident before they were moved and brought to the dining area, after which time a physical assessment of the resident was completed. The notes further indicated that RPN #127 had not properly assessed the resident and the home's falls policy indicated that staff needed to immediately complete an initial physical assessment and neurological assessment.

A review of the home's policy titled ""Fall's Management - RC-06-04-01" revised date May 2016, indicated the following interventions for post fall management:

-immediately complete an initial physical and neurological assessment; and
-determine if the resident can be safely monitored and treated within the home or if transfer to acute care is required

During an interview with the DOC they reported to Inspector #577 that RPN #127 had failed to immediately assess the resident prior to the staff moving the resident and did not immediately inform the RN. [s. 8. (1)]

2. Ontario Regulation 79/10, s. 114 (2) indicates that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Inspector #625 conducted a count of narcotics and controlled substances with RPN #103 on a specific day during the inspection. During the count, Inspector #625 identified that the last recorded count quantity was greater than the actual quantity of narcotics and controlled substances recorded on the "Narcotic and Controlled Drug Administration Record" for residents who had been administered narcotics or controlled substances since the last shift count. The record for resident #002's narcotic medication listed 20 as the count, when the blister pack contained 19 tablets; and the record for resident #028's

narcotic medication listed 54 tablets as the count, when the blister pack contained 52 tablets.

During an interview with Inspector #625, RPN #103 stated that the count on the "Narcotic and Controlled Drug Administration Record" was only to be updated at the end of every shift, and not at the time of administration of a narcotic or controlled substance throughout the shift.

During an interview with Inspector #625, the DOC stated that the count value recorded on the "Narcotic and Controlled Drug Administration Record" should be written after each administration of the narcotic or controlled drug, and not just after each shift count. The DOC reviewed the record for resident #028 and stated that the quantity had not been updated to reflect that 52 tablets were present, but should have been after administering the tablets.

A review of the home's pharmacy provider's sample completion sheet for the "Narcotic and Controlled Substance Administration Record" identified that an entry, including the current count, was to be made at the time the narcotic or controlled substance was removed for administration to a resident. [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 that ensures where the Act or Regulation required 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 plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On two specific dates, during the inspection, Inspector #625 observed the following:
- a resident room had holes in the drywall where an item had previously been mounted to the wall;
- a resident room had a deep groove in four consecutive floor tiles filled with black debris;
- a resident room had ripped drywall taped with medical tape and the wall above a bed had five holes in it, the baseboard beside the closet was missing with gouges present in the wall exposing drywall and metal edging on the wall, gouges in the wall beside the washroom door of approximately 30 centimeters in diameter, the wall beside the bathroom door had six holes in it, the floor near the side of the bathroom door was broken and had black debris collected in the cracks and the door handle to the bathroom had one screw missing and was loose.

A review of the home's quarterly scheduled work order "Resident Room Maintenance Audit" identified tasks to be completed during the audit, including inspecting walls, ceilings and floors in resident bedrooms.

A review of the last completed "Resident Room Maintenance Audit" created on a specific date in the summer of 2016, identified that the tasks were due on August 31, 2016, but that the tasks had been started, completed and closed on August 3, 2016. The location of the audit identified that it was completed in residents' bedrooms in the home, including resident rooms as listed previously.

During an interview with Inspector #625 the Environmental Services Manager (ESM)

stated that the quarterly "Resident Room Maintenance Audits" had been completed on every resident room in the home. On a specific date during the inspection, the ESM attended a specific resident room with Inspector #625 and confirmed that the room had cracked flooring with missing pieces near the washroom, gouges in the wall near the washroom and holes in the drywall where a previously mounted shelving unit had been. The ESM stated that items in the room required repair. The Inspector and ESM also attended another resident room where it was observed that a cable cord directly entered a hole in the wall that had no cover for the cable outlet. The ESM stated that a cable outlet cover would be installed. [s. 15. (2) (c)]

2. On a specific date, during the inspection, Inspector #625 observed the heater spanning the wall in a particular resident room to have a cover piece missing from the middle portion, exposing the interior components of the heater.

On a specific date, during the inspection, Inspector #625 and the Environmental Services Manager (ESM) #102 attended another resident room. The ESM #102 confirmed that the heater was missing a cover piece, and that the piece would need to be replaced.

During the inspection, Inspector #625 observed the following:
- a resident room's washroom counter had chipped paint;
- the toilet in a resident room was leaking around the base, the toilet tank to make a loud noise every few minutes and the grab bar was noted to be rusting;
- the grab bar in a resident room's washroom was loose and the sink was cracked around the perimeter.

On another date during the inspection, Inspectors #196 and #625 observed the towel bar in a resident room to be missing with only one side mounted to the wall and the toilet in another resident room to be running.

During an interview with Inspector #625, the ESM #102 attended specific resident washrooms with Inspector #625 and acknowledged that a resident room washroom counter had chipped paint requiring repair, that the resident's room washroom grab bar had been rusted requiring replacement and toilet had black stained caulking around the base requiring repair, that a resident room's washroom sink was cracked around the perimeter requiring replacement and grab bar was loose requiring repair, that a resident's room towel bar was missing one mount and the towel bar itself, and a resident's room toilet was running requiring a new lever. The ESM #102 stated that, outside of noting and correcting any deficiencies during quarterly maintenance audits of resident

washrooms, the Housekeeping staff were expected to notify the ESM of any repairs that were required in resident washrooms in person or by work order, and that Housekeeping staff had not notified the ESM of the maintenance required in the washrooms identified. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A Critical Incident System (CIS) report was submitted to the Director in the summer of 2016 for an incident of abuse by PSW #131 towards resident #024. The report identified that RN #108 had overheard PSW #131 speak inappropriately to the resident and tell them they didn't need to perform a specific activity of daily living.

During the inspection, an interview was conducted by Inspector #196 with the DOC. They reported that PSW #131 received disciplinary action in response to the incident of abuse towards resident #024.

Inspector #196 reviewed the policies in the "Zero Tolerance of Resident Abuse and Neglect Program - RC-02-01-01" last revised April 2016. The policy identified verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident..." and examples included "inappropriate tone of voice..". The policy also identified that "Extendicare is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and protected from all forms of abuse or neglect at all times" and "Extendicare has a zero tolerance for abuse. Any form of abuse by any person interacting with residents, whether through deliberate acts or negligence will not be tolerated". [s. 20. (1)]

2. On a specific date during the inspection, at approximately 0950 hours, Inspector #625 observed resident #029 request an meal item during two separate interactions, on behalf of resident #010, from RN #108 and a PSW who were in the open common area on one of the home's units. Inspector #625 approached the area and observed RN #108 and RN #109 near the nursing station, and approximately ten residents seated in the common lounge area. Approximately two minutes following these requests, Inspector #625 heard PSW #107 speak inappropriately to resident #029 and made a specific statement. Inspector heard PSW #107 continue to speak inappropriately and make specific statements to which the resident replied a specific statement. Inspector #625 had not heard resident #029 make any comment to PSW #107 prior to this statement.

During an interview with Inspector #625 immediately following the incident, PSW #107 stated that they had been speaking inappropriately to resident #029 because this resident always speaks inappropriately to them. When Inspector #625 asked PSW #107 if speaking to a resident in that manner was an appropriate way to speak to a resident, PSW #107 stated that this resident does the same to them. When asked if an employee speaks inappropriately to a resident was an appropriate way to speak to a resident, the PSW #107 stated it was not and they should not have spoken inappropriately to resident #029.

Inspector #625 then interviewed RN #108 and RN #109 to determine what they had witnessed and how they had responded. RN #108 stated that they had heard parts of what had transpired as they were helping another resident down the hallway. RN #109 stated that they had heard an inappropriate interaction but did not know what it was about. When asked by the Inspector if RN #109 had followed up to find out what had

occurred, the RN stated that they had not.

Inspector #625 observed resident #029 leave the common area and enter their room. Inspector spoke to the resident who stated that the PSW was mean to them, that they were just trying to help another resident, and that some of the staff were mean to the resident on more than this occasion.

A review of the home's "Zero Tolerance of Resident Abuse and Neglect Program– RC-02 -01-01" last revised April 2016, identified that the licensee was committed to provide a safe a secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. The policy also indicated that the licensee had a zero tolerance for abuse, and any form of abuse by any person interacting with residents, would not be tolerated. The policy indicated that all staff were required to protect, detect and immediately respond to any alleged or suspected incident of resident abuse or neglect.

The policy defined verbal abuse, as defined in Ontario Regulation 79/10, to be any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. Examples listed included inappropriate tone of voice, abusive language and yelling.

During an interview with Inspector #625, the DOC stated that they had initiated the process required with respect to the incident involving PSW #107. An investigation was started and they had spoken to the RNs involved about following-up when overhearing inappropriate verbal communication and that they had discussed with the RNs their roles in responding to abuse. The DOC also acknowledged that the resident should not have had to request a meal item from three employees prior to it being provided, as it should have been provided upon the first request. [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 that ensures the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

A complaint was submitted to the Director regarding a lack of staff within the home and care not being provided to the residents.

On a specific day during the inspection, an interview was conducted with PSW #106 regarding the provision of care to the residents on that day shift on one of the units. They reported that specific personal care was not provided to resident #012 that day shift as there were only two PSWs on the unit and not all care was provided to the residents as required. In addition, PSW #106 identified that residents #010, #002, #009 and #028 did not receive specific areas of personal care as required.

The health care records for residents #010, #002, #028 and #009 were reviewed for the documentation of the care provided. The flow sheet documents for residents #010, #002, #009 and #028 did not identify that specific areas of personal care were documented as being completed. A list indicating specific care for the unit identified that on a specific day of the week, on a specific shift, residents #010, #002 and #028 were to have received specific personal care.

On a specific day during the inspection, Inspector #196 conducted an interview with the DOC. They reported that at the present time, of 19 PSW rotations in the home, a combination of full and part time, and three full time and two part time positions were not filled due to leave of absences. [s. 31. (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 that ensures the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures.

During stage one of the inspection, resident #012 was identified as requiring further inspection, related to having been observed with a build up of food debris on their teeth.

On another date during the inspection, Inspector #196 observed resident #012 to have food debris on their teeth and the resident reported that staff did not assist them to brush their teeth that morning as was requested.

The health care records for resident #012 were reviewed. The current care plan identified that the resident required assistance with oral care.

Inspector #196 reviewed the home's policy titled "Oral Assessment and Care - RC-08-01-03" last updated June of 2016. The policy included "provide mouth care, as per resident's care plan, twice per day and more often as required, using person-centred techniques".

An interview was conducted with PSW #106 and they reported that oral care was not provided to resident #012 that day. [s. 34. (1) (a)]

2. The licensee has failed to ensure that residents were offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker (SDM), if payment was required.

During the inspection, residents #004 and #007 were identified as having dental care issues.

Inspector #577 conducted a review of the health care records for the residents which failed to identify any annual dental assessments or other preventative dental services.

During a record review of the home’s policy titled "Oral Assessment and Care - RC-08-01 -03” last updated June of 2016, indicated that referrals to oral health professionals would be made based on the oral assessment and in consultation with the resident/SDM and refer to Medical Doctor/dentist as appropriate, when medical intervention was required to address oral health issues.

During an interview with RPN #128 and they reported not all residents were offered an annual dental assessment.

During an interview with RPN #103 they reported that residents were not offered an annual dental assessment, but if there was a dental concern, the physician would order a dental assessment and the resident would see a dentist.

An interview with the DOC confirmed that some residents were offered an annual dental assessment by a dental hygienist from an agency centre in April of 2016. They further reported to Inspector #577 that the other residents were not offered an annual dental assessment, but if dental concerns arose, family were notified and arrangements were made. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures all residents are offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment was required, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

On a specific date during the inspection, Inspector #577 observed the residents' personal items in the tub rooms to be unlabelled and unclean. Inspector found the following:

1) Resident Unit
-Tub room #2: one unlabelled, used Arrid stick deodorant

2) Resident Unit
-Tub room #1: two unlabelled electric shavers, one unlabelled, used Aim toothpaste and one unlabelled denture brush
-Tub room #2: one unlabelled, used Arrid stick deodorant and one unlabelled, used Aim toothpaste.

During an interview with PSW #132, Inspector #577 showed them the unclean, unlabelled personal items in the tub rooms and they reported that all personal items should be labelled and they discarded them. They could not identify which resident the items may have belonged to.

During an interview with RPN #128, Inspector #577 showed them the unclean, unlabelled personal items in the tub rooms. They reported that all personal items should be labelled.

Inspector #577 spoke with the DOC who reported that all resident's personal belongings must be labelled. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #10: 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 has failed to ensure that the organized and social activities program for the home required under subsection 10(1) of the Act included the implementation of a schedule of recreation and social activities that were offered during weekends.

During an interview with Inspector #625, resident #002 stated that activities were not offered in the home on the weekends.

Inspector #625 reviewed the home's calendar of activities for July 2016. Weekend activities were listed on ten dates in July, beginning at 0930 hours, 1000 hours, 1400 hours and/or 1500 hours.

A review of the "Programming Schedule" for July 2016 revealed that no staff were scheduled to work on one weekend date in July, and that programming staff were

scheduled to work evening shifts on four weekend dates in July.

In July 2016, on one out of ten weekend days, or ten per cent of the time, no activities listed on the activity calendar were provided; and on three out of ten weekend days, or 30 per cent of the time, the majority of the activities listed on the home's activity calendar were not provided.

Inspector #625 reviewed the home's calendar of activities for August 2016. Weekend activities were listed on eight dates in August beginning at 0930 hours, 1000 hours, 1400 hours and/or 1500 hours.

A review of the "Programming Schedule" for August 2016, revealed that programming staff were not scheduled to work on six weekend days in August 2016. On one date in August, programming staff were scheduled to work an evening shift.

In August 2016, on six out of eight weekend days, or 75 per cent of the time, no activities listed on the activity calendar were provided; and on one out of eight weekend days, or 12.5 per cent of the time, the majority of activities listed on the activity calendar were not provided.

During an interview with Inspector #625, the Recreation Manager #101 stated that evening staff worked from 1200-2000 hours and confirmed that, in August 2016, on 75 per cent of the weekend days, no activities had been provided as the Manager had not scheduled programming staff to work, and that on 12.5 per cent of the weekend days, the majority of activities listed on the activity calendar were cancelled as the Recreation Manager had scheduled programming staff to start work at 1200hrs." [s. 65. (2) (b)]

2. The licensee has failed to ensure that the organized and social activities program for the home required under subsection 10(1) of the Act included the implementation of a schedule of recreation and social activities that were offered during evenings.

During an interview with Inspector #625, resident #011 stated that activities were not offered in the home during the evenings, that the evenings were boring and that residents just sat around.

Inspector #625 reviewed the home's calendar of activities for July 2016. Evening activities were listed as "friendly visiting" on nine dates in July. A review of the "Programming Schedule" for July 2016, revealed that no staff worked evenings on the

nine dates listed in the calendar as having scheduled evening programs. In July 2016, on nine out of nine evenings, or 100 per cent of the time where evening activities were listed on the activity calendar, no programming staff worked the evening shift.

Inspector #625 reviewed the home's calendar of activities for August 2016. Evening activities were listed as "friendly visiting" on ten dates in August. A review of the "Programming Schedule" for August 2016, revealed that no staff worked evenings on the ten dates listed in the calendar as having scheduled evening programs. In August 2016, on ten out of ten evenings, or 100 per cent of the time where evening activities were listed on the activity calendar, no programming staff worked the evening shift.

During an interview with Inspector #625, the Recreation Manager #101 acknowledged that, in July and August 2016, no evening programming was provided as listed in the home's activity calendar as the Recreation Manager had not scheduled staff to work on those evenings. [s. 65. (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 that ensures the organized and social activities program for the home required under subsection 10(1) of the Act includes 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, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

On a specific date, during the inspection, at 0930hrs, Inspector #196 observed resident #009 to be unshaven.

The health care records for resident #009 were reviewed for information regarding hygiene care and grooming needs. The current care plan under the focus of "Hygiene/Grooming" included the intervention of "staff to shave daily". The daily care flow sheets, for seven days in 2016, did not contain documentation of the care provided, specifically shaving, on any of these days and there was no documentation of resident refusal to be shaved.

The home's policy titled "Daily Personal Care and Grooming - RC-08-01-01" last updated June of 2016, was reviewed and indicated that "A.M. personal care" included shaving.

On a specific date, during the inspection, an interview was conducted by Inspector #196 with RN #108. They reported that the daily shave entry in the care plan was not attainable by the staff as they were too busy to do it every day. An interview was conducted with PSW #125 and they reported that resident #009 was to be shaved when they have their bath/shower, twice a week. [s. 32.]

2. On a specific date, during the inspection, Inspector #625 observed resident #003 to have a stain on the front of their shirt.

The following day, Inspector #625 observed resident #003 to be wearing what appeared to be the same shirt, with the same stain, and additional stains on the front and sleeve of the shirt.

A review of resident #003's current care plan identified that staff were to provide specific assistance to resident #003 to dress and were to ensure the resident's clothing was clean and appropriate.

During an interview with Inspector #625, RN #108 confirmed that resident #003's shirt was not clean and had multiple stains on the front of the shirt. The RN stated that staff were to provide specific assistance to the resident when dressing to ensure they were addressed appropriately. [s. 32.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home responded in writing within ten days of receiving Family Council advice related to concerns or recommendations.

During an interview with Inspector #625 , Family Council member #133 stated that the Family Council had not received a written response to their concerns and recommendations made through the Family Council meetings.

Inspector #625 reviewed the two most recent meeting minutes available dated May 2016, and May 2015, both of which contained concerns and recommendations from the Family Council. The minutes from the May 2015 meeting identified concerns including staff not answering call bells in a timely manner; laundry odours and a change of laundry times, and elevator maintenance. The minutes from the May 2016, meeting included suggestions, recommendations and concerns including painting of resident rooms different colours to promote a home-like atmosphere, a broken television on the second floor needing repair or replacement, and questions about volunteer recruitment.

During an interview with Inspector #625, the Executive Director (ED)stated that they could not identify when they had received the minutes of the Family Council as they were not dated, but acknowledged that they had not responded in writing to the concerns or recommendations listed in the minutes from May 2015 or May 2016, although both had been received greater than 10 days prior to the date of the interview. [s. 60. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During an interview with Inspector #625, Family Council member #133 stated that the results of the home's satisfaction survey had not been shared with the council, and that the council had not been consulted in acting on the results of the survey.

A review by Inspector #625 of the two most recent Family Council meeting minutes available from meetings in May 2015 and May 2016, identified no entries related to the review of the satisfaction survey results from the 2015 surveys.

During an interview with Inspector #625, the Executive Director (ED) stated that the results of the 2015 satisfaction surveys had not been shared with the Family Council, and that the home had not sought out the Family Council's advice on acting on the results of the survey. [s. 85. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During observations of resident rooms, on two consecutive days, two shared resident rooms had strong odours of urine and/or feces.

On another date, during the inspection, Inspector #196 and Inspector #625 went with the Environmental Services Manager (ESM) #102 to observe the previous noted rooms that had odours. The urine odour in both shared resident rooms was noted and was acknowledged by ESM #102. Later that same day, both resident rooms were observed and the urine odours remained, and were confirmed by ESM #102.

According to the ESM, the housekeeping staff had a enzymatic odour neutralizer spray to use in areas of odours and would spray on the toilet and the floor area around the toilet. In one resident room, the ESM reported that a "Sanvox" unit was above resident #008's bed and determined that the unit was not working and that the housekeeping staff should have identified that it wasn't working and informed the ESM. [s. 87. (2) (d)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, as part of the organized program of laundry services under clause 15 (1) (b) of the Act, that procedures were developed and implemented to ensure that, residents' linens were changed at least once a week and more often as needed.

During stage one of the inspection, a bed in a resident room was observed by Inspector #196 and was noted to have a strong odour of urine and the bottom bed linen had a large area of wet, yellow stain.

At 1610hrs, that same day, the resident room continued to have a strong odour of urine emanating from bed one and the bed was observed to be made. The urine odour and the presence of a large urine stain on the bottom bed linen was brought to the attention of RPN #103. They reported that the bed had been made by a Quality Assistant staff member and that the linen should have been changed and replaced with a clean sheet before the bed was made. [s. 89. (1) (a) (i)]

2. The licensee has failed to ensure that as part of the organized program of laundry services procedures are developed and implemented to ensure that there is a process to report and locate residents' lost clothing and personal items.

During the inspection, resident #002 reported to Inspector #625 that they had a particular piece of clothing that had been missing for weeks and they reported it to the laundry department.

During the inspection, resident #003 reported to Inspector #196 that they had a particular piece of clothing that had gone missing a few times in the past month and many times other pieces of clothing had not returned from laundry and they reported the missing clothing to staff.

During the inspection, resident #001 reported to Inspector #196 that they had missing particular pieces of clothing staff had told them that they would look for the clothing but they were never found.

During an interview with PSW #126, they reported to Inspector #577 that the procedure to locate lost clothing was, they would search the unit for missing clothing, call laundry and inform registered staff. They further reported that the registered staff would inform

the management.

During an interview with RPN #134 regarding the procedures to locate lost clothing, they reported that staff would search for missing clothing.

During an interview with RPN #103 regarding the procedures to locate lost clothing, they reported that staff were to fill out an inventory form for resident clothes and then clothes are sent to laundry for labelling. They further reported that they would document a complaint form and forward it to the DOC for missing clothing.

During a review of the home's policy titled "Missing personal clothing - HL-06-03-12" revised date September 2015, Inspector #577 found the following:

-registered staff: if a complaint related to missing clothing were received, notify the laundry staff promptly, along with the necessary information to conduct a search for clothing in the laundry area;
-inform the unit's care staff of the complaint and instruct them to search the unit for the reported missing clothing; and
-document information on the "Missing clothing search form".

During an interview with the DOC, they reported to Inspector #577 that when clothing or personal belongings were missing staff would document on the complaints form and forward to the DOC or Executive Director (ED). They further reported that they were unaware of missing clothing for resident's #001, #002 and #003 and there weren't any received forms documented for the missing clothing. [s. 89. (1) (a) (iii)]

Issued on this 13th day of January, 2017

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

Ministére 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), DEBBIE WARPULA (577), KATHERINE BARCA (625)
Inspection No. / No de l'inspection :	2016_512196_0015
Log No. / Registre no:	022136-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 10, 2017
Licensee / Titulaire de permis :	CVH (No.2) LP c/o Southbridge Care Homes, 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	BIRCHWOOD TERRACE 237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rochelle Torres

To CVH (No.2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministére 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 : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_246196_0010, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is ordered to ensure that the care set out in the plan of care is provided to all residents as specified in their plans of care.

The licensee is specifically ordered to:

a) ensure that the care set out in the plan of care for resident #025 is provided as specified in the plan.
b) complete training of registered staff members regarding resident's "Advance Directives" documents and the medical assessments and procedure to follow to ensure timely resident transfer to an acute care facility as may be required.

Grounds / Motifs :

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

As part of the RQI, a follow up inspection regarding Compliance Order #001 was conducted. This order had been issued during Inspection #2016_246196_0010 with a compliance date of September 2, 2016. The licensee was ordered to ensure that the care set out in the plan of care was provided to all residents as specified in their plans of care.

In the summer of 2016, a Critical Incident System (CIS) report was submitted to the Director for an incident. The mandatory report identified the category of "improper/incompetent treatment of a resident that results in harm or risk to a resident". According to the report, resident #025 had complained of a change in

their physical condition early in the morning on a specific date, but was not transferred to the acute care hospital until after a physician's order for transfer was received hours later.

The health care records for resident #025 were reviewed by Inspector #196. The "Advance Directives" document signed by the resident identified that "if symptoms indicate, the resident would be transferred to an acute care hospital for treatment. Assessment would be made in the acute care hospital emergency department and a decision made whether to admit the resident or return him/her to the Extendicare facility. No cardiopulmonary resuscitation is requested and no admission to an acute care intensive care unit."

The progress notes documented on the date of the incident identified that the resident had complained of a change in their physical condition. Later that same day, another note identified continued change in the resident's physical condition and included that a message was left for the physician. Additional progress notes during the day shift continued to document the declining physical condition of resident #025. Later that day, several hours after the resident had first complained of a change in their physical condition, the resident was transferred to hospital.

During the inspection, Inspector #196 conducted an interview with the Director of Care (DOC) regarding the investigation into the improper care of the resident #025. The DOC reported that the investigation had not been conducted in entirety and interviews with some of the staff present on the day of the incident had not yet been done. In addition, they reported that the resident should have been sent to the hospital when symptoms had first appeared and staff should not have waited for a physician's order to send the resident to hospital. The DOC acknowledged to the Inspector, the plan of care, specifically, the advance directives as signed by the resident included transfer to acute care hospital based on their symptoms they were experiencing, and this was not done.

Previous non-compliance related to this legislation, LTCHA 2007,S.O.2007,c.8,s.6, was issued during the following inspections:

July 12, 2016 - Compliance Order and Director's Referral from Inspection #2016_246196_0010;
January 21, 2016 - Compliance Order issued from Inspection #2016_339617_0004;

July 6, 2015 - Compliance Order issued from Inspection #2015_246196_0011;
August 5, 2014 - Written Notification/Voluntary Plan of Correction issued from Inspection #2014_211106_0014;
July 7, 2014 - Written Notification/Voluntary Plan of Correction issued from Inspection #2014_211106_0012;
April 14, 2014 - Written Notification/Voluntary Plan of Correction issued from Inspection #2014_333517_0005.

The decision to re-issue this Compliance Order was based on the scope which affected two residents which resulted in a pattern, the severity which indicated actual harm or potential risk of actual harm and the compliance history.

Despite the issuance of three Compliance Orders with a Director's Referral, and three Written Notification/Voluntary Plan of Correction in the past three years, the licensee continues to be in non-compliance with s.6.(7).

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee is ordered to ensure that for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee is specifically ordered to:

a) ensure that residents are protected from specific responsive behaviours demonstrated by resident #004 and all other residents in the home.
b) review, revise and update the plans of care for resident #004 and all other residents, including the care plan to ensure that interventions are effective to protect other residents from specific responsive behaviour demonstrated by resident #004 and by other residents.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

During an interview in stage one of the Resident Quality Inspection, resident #007 reported to Inspector #577 that resident #004 scares them because they

have displayed specific responsive behaviours. They further reported that resident #004 displayed specific responsive behaviours towards residents who cannot help themselves and the other residents get scared.

On a specific date, during the inspection, resident #004 approached Inspector #577 in a particular manner and displayed specific responsive behaviours. The resident proceeded to walk out into the hallway and Housekeeping Aide #116 brought the resident to their bathroom. The resident displayed specific responsive behaviours to the housekeeper. Ten minutes later, the Inspector observed resident #004 seated on a sofa in the television (tv) lounge, displaying specific responsive behaviours. A few minutes later, an unidentified PSW escorted the resident to their room while the resident was displaying specific responsive behaviours.

During an interview with PSW #117 they reported to Inspector #577 that resident #004's behaviours included specific responsive behaviours towards staff and residents. Staff were to verbally re-direct the resident and offer them snacks.

During an interview with PSW #110 they reported that resident #004's behaviour included specific responsive behaviours. Staff were to redirect the resident to their room and attempt to provide the resident with a particular item and complete two other interventions. They further reported that resident checks were initiated on a specific day and would end two days later.

During an interview with the outside agency PSW #118, they reported that resident #004 was referred to them approximately a year previous for various responsive behaviours. They further reported that the resident was discharged from their program approximately two months later because the suggested interventions had not been followed by staff. They further reported that the resident should have been re-referred for these current responsive behaviours.

During a record review of resident #004's progress notes, Inspector #577 found documented incidents of inappropriate behaviour towards staff and co-residents over an approximate ten month period. Inspector #577 conducted a record review of resident #004's current care plan and found the following interventions related to inappropriate behaviour, initiated at the start of that 10 month period:

- resident to be verbally prompted to deter from and discourage inappropriate behaviour; when seen doing so, resident would be informed that this

inappropriate behaviour, when heard or seen
-if this intervention does not work, report to registered staff

During a record review of residents health care records, Inspector #577 found documentation for the Dementia Observation Scale (DOS) initiated during a ten day period in 2015. This DOS revealed episodes of specific responsive behaviour. The DOS, one year later, during a five day period, revealed responsive behaviour during the evening hours and episodes of specific behaviour.

During an interview with the DOC, they reported to Inspector #577 that they were not aware that resident #004 had specific responsive behaviours over the past approximate ten months and thought the behaviours were more recent. They further reported staff were monitoring the resident by initiating a recent DOS, altering the environment and staff were to dress the resident in a specific way. The DOC confirmed that staff should have referred the resident to the outside agency for further assessment when the resident started showing specific responsive behaviours at the beginning, approximately ten months previous.

During an interview with the DOC they further reported to Inspector #577 that the home's Resident Service Coordinator #119 was to have sent a referral to an outside agency approximately ten months previous and did not process the referral.

Previous non-compliance related to this legislation, O.Reg.79/10,s.53(4) was issued during the following inspection:

August 5, 2014 – Written Notification/Voluntary Plan of Correction issued from Inspection #2014_211106_0014.

The decision to issue this Compliance Order was based on the scope which affected several residents and several occurrences which resulted in a pattern, the severity which indicated actual harm or potential risk of actual harm and the compliance history.
(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2017

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
Long-Term Care Inspections 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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 10th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

Service Area Office /
Bureau régional de services : Sudbury Service Area Office