Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 6, 2017	2016_293554_0022	013430-16	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

Chartwelll Bon Air Long Term Care Residence
131 Laidlaw Street South Cannington ON L0E 1E0

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

KELLY BURNS (554), CATHI KERR (641), JULIET MANDERSON-GRAY (607)

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): October 31, 2016 and November 01-04, 2016

Intake #013430-16; the following intakes were inspected concurrently with the Resident Quality Inspection, intakes, #023628-16, #029011-16, #030229-16 and #031583-16.

Summary of Intakes:

1) #023628-16 - Critical Incident Report (CIR) - allegations of improper care or treatment of a resident;
2) #023628-16 - Critical Incident Report (CIR) - incident that causes an injury to a resident for which the resident is taken to hospital, and which results in a significant change in the resident's health status;
3) #030229-16 - Critical Incident Report (CIR) - allegation of staff to resident abuse;
4) #031583-16 - Critical Incident Report (CIR) - incident that causes an injury to a resident for which the resident is taken to hospital, and which results in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with Administrator-Director of Care, Assistant Director of Care, RAI-Coordinator, Program and Support Services Manager, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Maintenance Worker, Restorative Care Aid(s), Housekeeping Aid(s), a Nursing Student, the Physician, President of the Resident Council, President of the Family Council, Corporate Nurse Consultant, Family and Residents.

During the course of this inspection, the inspector(s) toured the long-term care home, observed staff to resident interactions, and provision of resident care, observed resident to resident interactions, reviewed clinical health records, home specific investigations related to Critical Incident Reports, maintenance request log binder, Resident Council Meeting Minutes, activity calendar for a specific time period, identified staff retraining records for 2015 and/or 2016, and reviewed home specific policies, specifically (but not limited to), Continence Care, Bed Systems, Medication Incidents, Order, Re-Ordering, Drug Destruction Record Book, Safe Transfers Program, Mechanical Lift and Resident Transfers, Abuse Allegations and Follow Up, Purpose of Infection Prevention and Control Guidelines, Antibiotic Resistant Organisms Prevention and Management, Precautions Required by Infectious Disease, and Routine Precautions and Additional Precautions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident.

Related to Resident #041:

Resident #041 has a history which includes infection or colonization. Resident #041 requires the assistance of staff for all activities of daily living.

Registered Nurse (RN) #100 and the Assistant Director of Care both confirmed (with the inspector, on a specific date) that resident #041 requires specific infection control measures to be taken due to colonization. There is signage outside of resident room’s door, identifying that contact precautions are in place.

The written plan of care (last reviewed on a specific date), for resident #041, was reviewed (by the inspector). The written plan of care failed to provide the planned care for resident #041, and/or the goals the care is intended to achieve; the plan of care further failed to provide clear directions to staff and others who provide direct care to resident #041, regarding infection prevention and control measures to be taken when providing care.

The Assistant Director of Care indicated (to the inspector, on a specific date) that the written care plan should have included the risk posed to others and interventions in place, and to be taken when caring for resident #041. [s. 6. (1)]

2. The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan, related to falls prevention.

Related to Intake #031583-16, for Resident #023:

Resident #023 has a history which includes physical limitations. Resident #023 is identified as being at risk for falls.

The clinical health record (written care plan, last review and revision for a specific date), for resident #023 directs the following:
- Falls risk, identified as “high” risk. Interventions include, remind resident to call for assistance and wait before getting up; staff will cue, and remind resident of correct use of an identified mobility aide.
- Resident requires assistance with walking and locomotion. Interventions include, provide supervision to extensive assistance when in an identified mobility aide and walking with another mobility aid by one staff.

Progress notes (within the clinical health record), written on an identified date, by registered nursing staff, detail the following:

- At an identified hour, resident #023 was walking using his/her identified mobility aide. Resident stated he/she felt dizzy, lost his/her balance and fell to the ground; resident fell onto his/her side. Resident #023 complained of discomfort; assessment was completed by a registered nurse. A call was placed to emergency services (911); resident was transferred to hospital for assessment.
- Resident #023 was admitted to hospital on an identified date for treatment.

Registered Practical Nurse (RPN) #102, who witnessed the fall of resident #023, indicated (to the inspector), at the time of the fall, resident #023 was ambulating with his/her identified mobility aide, but no staff were with him/her or supervising him/her. RPN #102 indicated resident complained of dizziness and before I could get to him/her, he/she fell to the ground.

The licensee has failed to ensure that care was provided as per the plan of care in that no staff were present and or assisting resident #023 during ambulation. [s. 6. (7)]

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 there is a process in place and monitored, ensuring there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident; and to ensure the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to the policy of continence care and bowel management.

Under O. Reg. 79/10, r. 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

Under O. Reg. 79/10, r. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home 3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).

Residents #008 was triggered in stage one of the RQI as being at low risk for incontinence who was frequently or fully incontinent according to the most recent assessment.

A review of the MDS RAP assessment dated for a specific date and completed by Registered Practical Nurse (RPN) #120 indicated the resident is incontinent and the registered staff will complete a full assessment for the resident.

A review of the home's policy, Continence Care (# LTC-CA-WQ-200-02-05) directs that:

Registered Staff will assess the level of continence of each resident, quarterly as part of the resident's quarterly review process. Any significant change in the continence status of the resident during the quarter will require a three day continence assessment.

A review of the assessment record in the home's electronic health record (Point Click Care) failed to locate that an assessment for resident #008 was completed on a specific date and/or thereafter. Further review indicated the last time a continence assessment was completed for resident #008 was approximately five months earlier.

Registered Nurse (RN) #100 and the Assistant Director of Care indicated that the expectation is continence assessments are to be completed on admission, quarterly and when there is a significant change with a resident. [s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to medication management systems.

Under O. Reg. 79/10, s. 114 (1), every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Under O. Reg. 79/10, s. 114 (2), 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.

The home's policy, Medication Incidents (#LTC-CA-WQ-200-06-11) states that the policy provides registered (nursing) staff with operational direction and guidance with respect to medication administration for residents. The policy directs the following:

- Medication errors will be reported immediately;
- The attending physician and or nurse practitioner is to be contacted when a medication; error occurs involving a resident for further directions.

Another of the home's policies, Order, Re-Ordering Destruction of Drugs; Drug Record Book (#LTC-CA-WQ-200-06-16) directs the following:

- On receipt of medications the registered (nursing) staff is to check the medication against the physician's order to ensure that it is correct and then initials and dates the Drug Record Book indicating receipt of the drug.

Related to Intake #031583-16, for Resident #023:

The clinical health record, for resident #023, was reviewed (by the inspector) for a period encompassing approximately six months, specific to a falls incident.

During the review of the clinical health record, specifically progress notes for the identified time period, the inspector noted, that an ordered medication (vitamin supplement) was being signed for as not available (code 9) on the electronic medication administration record (eMAR) when two identified registered practical nurses #102 and #118 were working. On all other dates, during the review period the medication was being signed for as administered by registered nursing staff at a specific hour daily (on eMAR).

Registered Nurse (RN) #100, who is the charge nurse, indicated (to the inspector, on a specific date) that resident #023's family requested to supply the ordered (identified) medication.

Registered Nurse #100, along with Registered Practical Nurse (RPN) #116 indicated (on an identified date) that resident #023's family supplied the identified medication to the

long-term home, to be used for the physician's order.

Registered Nurse #100 indicated that he/she spoke with the pharmacist on an identified dated during this inspection, about the identified medication; RN #100 indicated that the pharmacist stated that the medication, being administered to resident #023, is not consistent with the dosage which was prescribed by resident #023's physician's order, as it does not contain the correct dosage of medication ordered.

Registered Practical Nurses #116 (on a specific date) and #117 (on a specific date) both indicated (to the inspector) that they had administered the medication to resident #023, using the medication bottle currently inside the medication cart; administration was confirmed as per eMAR documentation.

The home's policies, specific to medication management systems were not complied with as per the following:

- Registered Nurse #100 did not immediately notify the physician (and or a nurse practitioner) of the medication error(s) which had occurred during a period of six months; the medication was wrongly administered to resident #023, 153 times. RN #100 was aware of the medication incidents on an identified date during this inspection.

- Registered Nurse #100 indicated (to the inspector) that there is no documentation within the Drug Record Book of which registered staff accepted receipt of family supplied medication for resident #023. RN #100 indicated there was no documentation as to the date as to when the medication was acquired by the long-term care home for resident #023.

Administrator-Director of Care indicated (to the inspector) it is an expectation, all staff, including that registered nursing staff, follow the home's policies and procedures. [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 there is a process in place and monitored, ensuring that any plan, policy, protocol, procedure, strategy or system, is complied with, specifically as such relates to continence care and bowel management, and medication management systems, to be implemented voluntarily.

WN #3: 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 failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

As of the date of this inspection, twelve of the fifty-five residents residing at the long-term care home, were identified and had a specific diagnosis (related to infection control and precautions required). This was confirmed to be correct by Registered Nurse #100 and the Assistant Director of Care.

The long-term care home has one tub room for use for bathing and or showering of residents. At the time of this inspection, twelve of the fifty-five residents in the home were identified as requiring varying infection control precautions.

On two separate dates during this inspection, a whitish film was observed (by an inspector) on the bath chair. The whitish film was visible on the seat, the underside of the seat, and on the movable arms of the bath chair. Brownish spots (unidentified substance) were also visible along the outer sides of the seating surface of the bath chair. Observations were made by the inspector, on four separate occasions during a two day period.

Personal Support Workers (PSW) #106 and #115 indicated (to the inspector) that the PSWs are to clean and disinfect the bath chair (and the tub) following each resident bath. Both PSWs indicated a disinfectant is sprayed onto the surface of the bathing chair, allowed to sit for approximately ten minutes and then the bath chair is rinsed with water. Both PSWs indicated that they use to have a brush to scrub the bath chair surface, but they no longer have a scrub brush available for use in cleaning the bath chair.

Registered Nurse #100 and PSWs #106 and #115 indicated (to the inspector) that there is no extra cleaning process in place for bathing of those residents having identified precautions.

Assistant Director of Care (ADOC), who is the lead for the Infection Prevention and Control Program, indicated (to the inspector) that the scrub brush for the cleaning of the bathing chair was removed at some point during the previous year, as it may have been a potential source for the spread of germs. ADOC indicated that the bathing chair is sprayed with disinfectant following each resident bath, but was unsure as to what else is being done to ensure the bath chair is clean and sanitary for use. ADOC indicated being unsure as to what the brown and white film was covering the seat of the bath chair.

The Administrator-Director of Care, who oversees the operations of the long-term care home, indicated (to the inspector) that the manufacturer of the bath chair provided the home in-service education during the past month, and recommended the use of a scrub brush to clean the bath chair (and the tub). Administrator- Director of Care indicated that she was not aware that the staff did not have access to a scrub brush to clean the bathing chair. Administrator-Director of Care indicated that lack of appropriate equipment (e.g. scrub brush) could be a contributing factor to the whitish film and or substance build-up on the bath chair. [s. 15. (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 there is a process in place and monitored, ensuring the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #4: 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 has failed to ensure that where bed rails are used, 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.

A review of the best practice guidelines recommended to Long-term Care Homes by Health Canada entitled “Adults hospital beds: Patient entrapment hazards, side rail latching reliability and other hazards” defines the zones as follows:

Zone 1: Within the Rail
Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support
Zone 3: Between the Rail and the Mattress
Zone 4: Under the Rail, at the Ends of the Rail

A review of the homes “Bed Entrapment Log” (dated for a specific time), indicated resident #027's bed uses a ¼ and ¾ bedrail. The log also indicated that both resident #026 and #027 mattresses were replaced in October 2016 and both residents use bedrails.

A review of the home's policy Bed Systems (# LTC-CA-ON-100-05-16) directs:

Chartwell homes will assess every bed system within the home to ensure compliance with bed entrapment standards as defined by Heath Canada. Bed Systems will be assessed whenever any component of the bed system is changed. This includes, not limited to:
- Bed rails
- Mattress changes
- Head or foot board
- Corner guard
- Bed padding

Further review of the home's bed entrapment log (by the inspector) also indicated that both resident #026 and #027 mattresses were replaced in October 2016 creating a new bed system, the new bed systems were not evaluated and an evaluation of the new bed systems were not completed for zones 1, 2, 3 or 4.

Interview with Restorative Aid #108 indicated, that the Maintenance Worker #101 is responsible for bed entrapment audits, and has been working for the home for only two weeks. Restorative Aid #108 further indicated that Personal Support Worker #106 is trained to assess bed rails for entrapment. Restorative Aid #108 further indicated that the Administrator-Director of Care oversees the environmental services department.

Interview with Personal Support Worker (PSW) #106 confirmed that an evaluation of the bed system for residents #026 and #027 were not completed, as PSW #106 was not aware that the mattresses had been replaced.

Interview with the Administrator-Director of Care could not confirm why the above identified bed systems were not evaluated after the mattresses were replaced. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that where bed rails are used, 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

On a specific date, during this inspection, two inspectors (#554 and #641) observed that a window in a room, identified as a "living room", within the long-term care home, was able to be opened approximately seventy-one centimetres. The same identified window did not have a screen in place. The "living room" lounge, of the long-term care home, is a resident accessible lounge; several residents were observed (by inspectors) entering the "living room" lounge on their own. The identified window opens to a second level, onto the stairs going down to the back yard.

Secondary observations (by the inspector), during this inspection identified the following:
- A window in the "family room" could be opened up to its maximum point, which was beyond fifteen centimetres; this window had no screen in place. This window was in a resident accessible area, where multiple residents were observed throughout the day. The window opened onto a secured courtyard.
- Windows in two identified resident rooms were observed to open to seventeen

centimetres.

The Administrator-Director of Care was notified (by an inspector) on November 01, 2016, of the windows being a concern (opening greater than fifteen centimetres).

Maintenance Worker #101 stated (to the inspector, on an identified date) that he/she had removed the air conditioners from the windows in the home on the previous Wednesday. Maintenance Worker indicated that the air conditioners were in the identified windows, and that he/she did not replace the screens or the bolt that prevented the windows from opening to their maximum point.

Registered Nurse (RN) #100 indicated (to the inspector) that there currently was one resident, in the long-term care home, who was identified as being at risk for elopement.

Inspector #641 spoke with the Administrator-Director of Care, and Maintenance Worker #101, on November 01, 2016. The Administrator-Director of Care stated that all of the windows had been fixed to meet legislative guidelines. Both indicated that the windows in the "living room" lounge, the family room and one window in the dining room now had the screens in place, and had a bolt on the slider (portion of the window) to prevent the windows from opening greater than fifteen centimetres. The Administrator-Director of Care stated that Maintenance Worker #101 had shorted all the chains on all of the other windows in the home, so that the windows could no longer open more than fifteen centimetres, as per the legislative requirements.

The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than fifteen centimetres. [s. 16.]

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 there is a process in place and monitored, ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, 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 license failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of resident is complied with.

The home's policy, Abuse Allegations and Follow-Up (#LTC-CA-WQ-100-05-02) directs, that, when a staff member receives a report of abuse or observes anyone abusing a resident in any manner, staff will:
- stop the abuse;
- separate the resident and the alleged abuser; staff are to take the resident to a quiet and safe location and have another staff member stay with them; direct the alleged abuser to an isolated location;
- ensure safety-immediately report the allegation to the ADM/DOC (Administrator/Director of Care) or the building supervisor following the internal reporting system for incident management;
- get help; the ADM/DOC/designate or building supervisor receiving the report will immediately go to the situation to ensure the safety of all involved.

Related to Intake #030229-16, for Resident #004:

On an identified date, and at an approximate hour, Personal Support Worker (PSW) #106 reported, to the Assistant Director of Care, that he/she witnessed an incident of staff to resident (verbal/physical) abuse, involving PSW #105 towards resident #004.

Personal Support Worker #106 indicated, in his/her report to the Assistant Director of Care, that on the identified date, PSW #105 was witnessed (by PSW #106) entering resident #004’s room, pulling off resident’s bed sheets, forcing resident to get out of bed, despite resident’s wishes, grabbing the front of resident’s incontinence product, and overheard saying (to the resident) you are soaking wet. During this time, resident #004 was heard saying that he/she was not feeling well and did not wish to get up.

The Assistant Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date, regarding the alleged staff to resident abuse incident.

Personal Support Worker #106 indicated (to the inspector, on a specific date) that he/she did not report the incident, of staff to resident abuse, to the Administrator/Director of Care and/or supervisor, until the next day. PSW #106 indicted he/she was unsure if what he/she witnessed was abuse, but realized it was abuse after leaving his/her shift on an identified date. Personal Support Worker indicated he/she realized that he/she should have intervened; PSW #106 further indicated that he/she should have reported the incident immediately to his/her supervisor. Personal Support Worker #106 indicated that he/she was aware of the home’s zero tolerance of abuse policy.

Administrator/Director of Care indicated (to the inspector, on an identified date) that the incident (alleged abuse) should have been reported immediately to him/herself or his/her designate (ADOC or RN Supervisor) as per the home's policy. [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 there is a process in place and monitored, ensuring that the written policy that promotes zero tolerance of abuse and neglect of resident is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care plan for resident #040 included any risks the resident may pose to others.

Resident #040 was admitted to the long-term care home on a specific date. Resident #040 has a history which includes specific infections. Resident #040 requires the assistance of staff for toileting.

Resident #040 resides in an identified room, and shares this room with a co-resident. There was signage outside of resident's room, identifying that contact precautions are in place.

Registered Nurse (RN) #100 and the Assistant Director of Care confirmed (with the inspector) that resident #040 has a specific diagnosis, which requires contact precautions to be taken. Assistant Director of Care, who is the lead for the Infection Control Program, indicated (to the inspector, on a specific date) that he/she was unsure if resident is infected or colonized with a specific organism as laboratory results have not yet been received by the long-term care home.

The admission care plan, in place at the time of this inspection (specific date), was reviewed (by the inspector, on an identified date); the care plan failed to provide documentation identifying the risk that resident #040 may pose to others, specific as such relates to specific diagnosis, and infection prevention and control measures to be taken when caring for resident.

The Assistant Director of Care, and the Administrator-Director of Care indicated the admission care plan for resident #040 should have identified risk based on an identified diagnosis and interventions to be in place when caring for this resident. [s. 24. (2) 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 there is a process in place and monitored, ensuring hat the care plan for resident #040 included any risks the resident my pose to others, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

The home's policy, Safe Transfer Program (#LTC-CA-WQ-200-07-15) states that the purpose of the program is to promote safety of the residents.

A second policy, Mechanical Lifts and Resident Transfers (#LTC-CA-WQ-200-07-12) directs that two staff are required at all times when a mechanical device is used to transfer and/or lift a resident.

Related to Intake #023628-16, for Resident #019:

The Assistant Director of Care (ADOC) submitted a Critical Incident Report (CIR), on a specific date, related to improper treatment and or care of resident #019, that resulted in harm or potential risk of harm.

Details of the CIR are as follows:

- On an identified date, a Personal Support Worker (PSW) #115 reported to ADOC that PSW #106 had allegedly transferred resident #019 using a mechanical transfer device, without the assistance of a second staff.

Resident #019 is cognitively well, and has a history which includes physical limitations. Resident #019 is dependent on staff for all transfers, and is at "high" risk for falls.

The clinical health record (written plan of care, last revision on a specific date) for resident #019 was reviewed (by inspector) and such directs the following:
- Resident requires assistance with transfers; interventions include (but not limited to), a mechanical transfer device is required and is to be operated by two staff.

Personal Support Worker #106 acknowledged, during the home’s investigation, being aware of the home’s policy and procedures around safe lifts and transfers of residents. PSW #106 further acknowledged not following the safe lifts and transfers policy, indicating he/she had transferred resident #019 without a second staff present, which placed resident at risk of harm.

Administrator-Director of Care indicated (to the inspector, on a specific date) all staff are expected to follow the home’s policies and procedures. In this incident, PSW #106 placed resident #019 at risk for injury and/or harm by not having a second staff present during the transfer. Administrator-Director of Care indicated all staff have been provided training on use of mechanical transfer devices and the need to have two staff present during the operation and use of the mechanical transfer devices.

According to the Critical Incident Report and during an interview, Administrator-Director of Care indicated resident #019 did not sustain injury during the incident. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that staff use safe transferring and positioning devices or techniques when assisting resident., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Related to Intake #031583-16, for Resident #023:

Resident #023 was admitted to the long-term care home on an identified date.

On admission, resident #023's attending physician prescribed the following:

- Medication (vitamin supplementation), and indicated a specific dosage to be administered. The physician's order directed, that one tablet. orally, was to be administered (to the resident) for medical conditions. The administration of the medication was to begin the day following admission to the long-term care home.

The clinical health record, for resident #023, was reviewed (by the inspector) for the period of approximately six months.

During review of the clinical health record, the inspector noted that an ordered medication (vitamin supplement) was being signed for as not available (identified as code 9) on the electronic medication administration record (eMAR) when two identified registered practical nurses #102 and #118 were working. On all other dates, during the review period, the medication was being signed for as administered by registered nursing staff at a specific hour daily, to resident #023.

Registered Nurse (RN) #100 indicated that the family of resident #023 requested to supply the identified medication.

Registered Nurse #100 opened the medication cart, and showed the inspector the bottle of medication supplied for resident #023, by his/her family. The medication label, on the bottle, indicated that the medication did not contain all the prescribed medication and or the correct dosage. The bottle was labelled with a black marker/pen, indicating medication was being used for resident #023 (name hand written). The bottle was approximately 3/4 empty.

Registered Nurse #100 contacted the pharmacy contracted by the long-term care home, by phone, on an identified date, to inquire as to the identified physician's order and the contents of the actual medication having been administered to resident #023, by registered nursing staff (since admission). RN #100 indicated that the pharmacist indicated that the medication being administered to resident #023 was not consistent with the medication prescribed, for resident #023, by his/her physician. RN #100 indicated the

medication administered was not the correct dosage as prescribed by the resident’s physician.

Registered Practical Nurses #116 (on an identified date) and #117 (on an identified date) both indicated (to the inspector) that they had administered the identified medication to resident #023, using the medication bottle located within the medication cart; this was confirmed by eMAR documentation. Both indicated that they were unaware that the medication they had administered to resident #023 did not contain the prescribed medication or correct dosage. Both registered practical nurses indicated they assumed what the family supplied was comparable to what the resident’s physician had ordered.

Administrator-Director of Care indicated (to the inspector, on a specific date) that it is an expectation that registered nursing staff administer medications as per the physician’s orders and ensure that if the family are supplying medication to the long-term care home, that the medication is the same dosage prescribed for the resident.

According to the electronic medication administration record, as well as interviews with RN #100, and RPN's #116 and #117, resident #023 received the wrong dosage of the identified medication, 153 times, during the period of approximately six months. [s. 131. (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 there is a process in place and monitored, ensuring hat drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home`s policy, Purpose of Infection Prevention and Control Guidelines (LTC-CA-WQ-205-01-01) states that the goal of the IPAC (Infection Prevention and Control Program) is to protect residents from health care associated infections, and to prevent the spread of infections from resident to resident, from residents to health care providers, and from health care workers to residents or visitors.

The home`s Infection Prevention and Control Program includes the following policies:

Antibiotic Resistant Organisms-Prevention and Management (#LTC-CA-WQ-205-03-01) policy, states that the purpose of the policy is to ensure appropriate screening, monitoring and management of residents who are colonized or infected with an Antibiotic Resistant Organism (ARO).

The policy, Antibiotic Resistant Organisms-Prevention and Management, further states that:
- There is evidence to show that rates of transmission of AROs are directly related to infection prevention and control practices in health care settings. AROs are most commonly spread via the transiently colonized hands of health care workers who acquire it from contact with colonized or infected residents, or after handling contaminated material or equipment.
- Residents will be treated and placed under additional precautions if the ARO is identified in a specific location.
- Residents testing positive for ARO’s will be placed on contact precautions (and or additional precautions) for direct care. If resident shares a room, dedicated equipment is required.

Precautions Required By Infectious Disease (LTC-CA-WQ-205-03-06) directs that AROs, all require contact isolation and or precautions to be in place.

Routine Precautions and Additional Precautions (#LTC-CA-WQ-205-03-07) directs that personal protective equipment - gloves and gowns are required for activities that involve direct care (e.g. bathing, washing, turning residents, changing resident clothes, continence care, wound care, toileting and mouth care) where the health care providers

skin and/or clothing may come in direct contact with the resident or items in the resident`s room or bed space.

The following observations were made:

On an identified date, during this inspection, Personal Support Workers (PSW) #106 and #119 were overheard (by an inspector) in the hallways indicating that they could not get five residents up for breakfast as the slings for the mechanical lifts were not available for the identified residents.

Personal Support Workers indicated (to the inspector) that they had gotten residents #038 and #039 out of bed using resident #010’s sling.

Personal Support Worker #106 indicated (to the inspector) that slings, for the mechanical lifts, were resident designated and that staff were not supposed to use one resident’s designated sling for another resident. PSW #106 indicated that we often do not have enough slings in the morning for care, so staff do share slings. PSW indicated that staff shouldn't share slings with a residents who are in isolation or on precautions. PSW #106 indicated that residents #010, #038 and #039 are all identified as having infections and that his/her co-workers shouldn't have used resident #010’s sling for either resident.

The clinical health record for residents #010, #038 and #039 were reviewed; the plan of care for each resident identified that all three residents had specific interventions in place, specifically related to designated mechanical transfer device and or personal care equipment, due to contact precautions in place.

Registered Nurse (RN) #109, who was the charge nurse on duty that shift, indicated (to the inspector) being aware that PSWs were unable to get five residents up for breakfast, due to slings not being available.

Personal Support Workers #106 and #119 indicated (to the inspector) that there are no spare slings available in the home.

Assistant Director of Care (ADOC) who is the lead for the Infection Prevention and Control Program indicated (to the inspector, during this inspection) that slings are designated for the assigned resident; ADOC further indicated, if a sling is soiled, PSWs may share slings between residents but not between residents in isolation or on precautions due to the risk of transmission of germs.

2. On an identified date during this inspection, Personal Support Worker (PSW) #113, was observed (by the inspector) coming out of a resident washroom with resident #008. PSW #113 assisted resident #008 into an identified bed and covered resident with his/her bed sheets. Signage on resident's room indicated resident in the identified bed was on contact precautions, and that staff were to wear a gown and gloves with care. PSW #113 was not wearing personal protective equipment (gowns or gloves) at the time of this observation.

Personal Support Worker #113 indicated awareness that resident #008 was on contact precautions. PSW #113 indicated awareness that gowns and gloves were to be worn during direct care. PSW indicated that he/she was not providing resident #008 care, but merely handing resident #008 his/her toiletries, while resident sat on the toilet. PSW #113 also indicated that he/she handed resident #008 his/her dentures. PSW #113 indicated, staff only needed to wear personal protective equipment (gown and gloves) if we are assisting resident #008 with specific care.

Personal Support Worker #113 indicated that he/she had been provided annual retraining specific to infection prevention and control, specifically hand hygiene, use of personal protective equipment and contact precautions.

Registered Nurse #109 indicated that staff providing direct care to a resident who is identified needing precautions is to wear gloves and gowns with care, and or other personal protective equipment as indicated by the signage on the resident's room door.

Assistant Director of Care indicated direct care would include mouth care, and such includes handing a resident dentures, or handing resident toiletries, especially if the resident was using the toilet at that time. [s. 229. (4)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the use of the PASD (personal assistance services device) has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #010 has a history that includes cognitive impairment. Resident #010 is dependent on staff for activities of daily living, and uses an identified mobility aid.

A review of an Occupational Therapy (OT) referral, dated for a specific date and hour, in the home's Electronic Point Click Care (PCC) system indicated this referral was sent on behalf of resident #010. The reason for referral was that resident #010 can no longer sit in his/her identified mobility aid safely, and for resident's safety was using a identified mobility aid, belonging to the long-term care home; referral was made to have the OT assess the identified mobility aid as a PASD.

Review of the above mentioned referral indicated that the OT did an assessment for resident #010 regarding the identified mobility aide and made the following recommendations, staff may still place a specific PASD on the identified mobility aid to support resident's upper extremities. The referral completed by the OT indicated that the Resident/Family/POA consent to referral is in progress.

A review of the resident clinical health records failed to identify or locate that consent for the PASD (identified mobility aide) was obtained by resident #010's SDM.

Interview with Registered Nurse (RN) #100 confirmed that resident #010 uses a specific mobility aid, as PASD, and consent was not in place for the said PASD.

Interview with Administrator-Director of Care and the Assistant Director of Care confirmed that consent for a PASD should be obtained by the OT; both indicated it is the expectation that a consent is obtained from the resident or resident's SDM prior to the PASD being put into place and annually thereafter. [s. 33. (4) 4.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident's substitute decision maker (SDM) and any other person specified by the resident were notified within twelve hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to Intake #030229-16, for Resident #004:

Resident #004 has a history which includes cognitive impairment. Resident has a specified Substitute Decision Maker for all care and financial decisions.

On an identified date, and at an approximate hour, Personal Support Worker (PSW) #106 reported, to the Assistant Director of Care, that he/she witnessed an incident of staff to resident (verbal/physical) abuse, involving PSW #105 towards resident #004. Personal Support Worker #106 indicated that the alleged incident occurred the previous day.

Critical Incident Report (CIR) indicated that the Assistant Director of Care did not notify SDM of the alleged staff to resident abuse incident. Assistant Director of Care confirmed (with the inspector, on a specific date) that he/she did not notify the SDM of the alleged abuse.

Administrator/Director of Care indicated (to the inspector, on a specific date) that the SDM was not notified of the alleged staff to resident abuse incident, until two weeks later (approximate). Administrator-Director of Care indicated this was the first notification of resident's SDM with regards to the alleged abuse of resident #004. [s. 97. (1) (b)]

Issued on this 9th day of January, 2017

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

Original report signed by the inspector.