Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 9, 2018	2018_486653_0005	002841-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Bradford Valley Care Community
2656 6th Line Bradford ON L3Z 3T5

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

ROMELA VILLASPIR (653), JOVAIRIA AWAN (648), SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 6, 7, 8, 9, 12, 13, 14, 15, 16, 22, 23, 26, 27, 28, March 1, 2, 5, and 6, 2018.

The following intakes were inspected concurrently during this inspection:
Complaint Log #s:
013724-17 related to falls prevention and management,
022257-17 related to continence care and bowel management, and insufficient staffing,
026237-17 related to abuse,
026878-17, 026879-17, 026880-17, 026883-17, related to insufficient staffing, medication administration, and continence care and bowel management.

Critical Incident Log #s:
024601-17, and 001212-18 related to abuse.

Follow Up Log #028115-17 related to responsive behaviours.

During the course of the inspection, the inspectors conducted a tour of the home, observed medication administration, observed staff to resident interactions, reviewed staff schedule, clinical health records, the home's investigation notes, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Behavioural Support Ontario (BSO) Nurses, Housekeeper, Staffing Coordinator, Dietary Aides (DAs), Director of Dietary Services (DDS), Registered Dietitians (RDs), Physiotherapist (PT), Nurse Manager (NM), Assistant Directors of Care (ADOCs), Director of Care (DOC), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 55.	CO #001	2017_650565_0010	116

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

s. 6. (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 has failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to the resident.

On an identified date, the home submitted a Critical Incident System (CIS) report to the Director, reporting an incident of resident to resident abuse. The report read as follows:

On an identified date and time, in an identified home area, a housekeeping staff saw resident #022 exhibit an identified responsive behaviour toward resident #024, while sitting on a chair in the corner of the TV lounge, while waiting for snacks and drink. The residents were separated.

Review of resident #022's written plan of care initiated on an identified date, indicated that the resident displayed inappropriate behaviour towards residents, and directed staff to frequently monitor resident #022 when in common areas with co-residents of an identified gender.

Interviews held with Personal Support Worker (PSW) #145 and Registered Practical Nurse (RPN) #130 provided different interpretations in regards to the required frequency of monitoring. RPN #130 indicated the definition of frequent was equivalent to every 30 minutes while PSW #145 stated the resident was monitored every hour to half an hour.

Further interviews held with Nurse Manager (NM) #104, Behavioural Support Ontario (BSO) nurses #146, #147 and the Director of Care (DOC) confirmed that resident #022's written plan of care did not set out clear directions to staff and others who provided direct care to the resident in relation to monitoring requirements of resident #022 when in common areas with co-residents of an identified gender. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONLine received a complaint on an identified date, log #022257-17, related to insufficient staffing that compromised the timely provision of resident #042’s care.

Review of resident #042’s written plan of care on an identified date, revealed they required total dependence on staff with an identified Activity of the Daily Living (ADL), and staff were directed to provide the identified care as needed.

Review of the Physiotherapist (PT)'s assessment as documented on resident #042's progress notes on two identified dates, and interview with the PT indicated that resident #042 was unable to follow commands and did not cooperate with the transfers. The resident was unable to weight bear and an identified equipment was now required for all transfers.

During an observation on an identified date and time, resident #042 was toileted by two PSWs in the tub room. The two PSWs applied a hygiene sling on resident #042, and used the identified equipment to transfer the resident from their personal device onto the toilet. The resident was provided with the identified care, and they were transferred back to their personal device.

Interview with PSW #132 when asked about the resident’s identified ADL routine, stated that in the evening, if the resident was in the common area, they would provide the

identified care in the tub room using the hygiene sling and the identified equipment. At night time before going to bed, they would use an alternative equipment to provide the identified care to the resident. Interview with PSW #114 when asked about the resident's identified ADL routine, stated that in the day, if the resident was cooperative with care, they would sometimes use the alternative equipment to provide the identified care to the resident.

Interviews with RPN #143 and Registered Nurse (RN) #148 stated that resident #042 required an identified equipment for all transfers, and that the PSWs were directed to provide the identified care to the resident in an identified manner.

Interview with the PT confirmed they had assessed resident #042, and noted the resident was unable to follow commands and did not cooperate with the transfers. The PT recommended for staff to use the identified equipment for all transfers, and indicated they had not been aware that staff continued to assist with resident #042's identified ADL in an identified manner.

Interview with the DOC acknowledged the above mentioned information and stated that the home's expectation was for the multidisciplinary team including the PSWs, registered staff, and the PT to collaborate with one another in the development and implementation of the resident's plan of care. [s. 6. (4) (b)]

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

On an identified date, the home submitted a CIS report to the Director, reporting an incident of resident to resident abuse. The report read as follows:

On an identified date and time, in an identified home area, a housekeeping staff saw resident #022 exhibit an identified responsive behaviour toward resident #024, while sitting on a chair in the corner of the TV lounge, while waiting for snacks and drink. The residents were separated.

Review of resident #022's written plan of care initiated on an identified date, indicated that the resident displays inappropriate behaviour towards residents and staff. One of the interventions in place to minimize the incidents of inappropriate behaviour, directed staff to reinforce the following: If resident #022 made any inappropriate comments or exhibit the identified behaviour toward others and staff, they should respond with the identified

statement.

On an identified date, resident #022 approached co-resident #023 in their own room and made an inappropriate statement to the resident. Resident #023 reported the incident to RPN #130.

An interview held with RPN #130 indicated having knowledge of resident #022's inappropriate behaviour and the interventions in place to minimize the behaviour. The RPN acknowledged that resident #023 reported the concerns to them, of which a referral had been made for external behavioural services through LOFT, however, RPN#130 did not reinforce the required statement to resident #022 to inform them that the behaviour was inappropriate as the RPN stated they did not witness the incident.

Further interviews held with the DOC and the Executive Director (ED) confirmed that the care set out in the plan of care to reduce incidents of inappropriate behaviour of resident #022 was not provided as specified, on the identified date. [s. 6. (7)]

4. The MOHLTC ACTIONLine received a complaint on an identified date, log #013724-17, regarding falls management and care concerns related to resident #007. The complaint identified resident #007 had a fall on two identified dates. The complaint identified resident was found on the floor and the identified device was not on the bed during the fall on an identified date.

Review of resident #007’s clinical records identified a fall on an identified date, with no injury and indicating the resident was being walked by staff in the room and that their legs gave out. Interventions to manage the resident's fall risk were revised.

Further review of resident #007’s written plan of care on an identified date, indicated resident #007 to be at risk of falls. Interventions to manage resident #007's falls included an identified device was to be used while the resident was in bed and while the resident was ambulating and using an identified assistive device.

Resident #007 was identified to have an unwitnessed fall on an identified date, and was found lying on the floor next to their bed. Documentation of the fall indicated that the resident was found without the identified device applied.

Interview with RN #138 indicated that PSW staff assigned to residents were responsible for ensuring residents have their identified devices attached to them if required. RN #138

revealed they had responded to resident #007's unwitnessed fall on an identified date, after being notified by staff. The RN reported that resident #007 was found on the floor without the identified device applied. The resident's ambulatory aid was next to the bed, and the identified device was attached to it and had not sounded when the resident was discovered on the floor. RN #138 further stated that the resident's identified device on the bed had not sounded either, and confirmed that the resident's written plan of care was not followed.

Resident #007's records and staff interviews regarding their falls history, and falls preventions strategies outlined in the written plan of care were reviewed with the DOC. The DOC indicated that all front line staff including PSWs and registered staff were responsible for ensuring falls prevention strategies such as the application of the identified device was provided to residents at risk of falls. The DOC acknowledged staff had failed to follow resident #007's written plan of care by not applying their identified device as directed. [s. 6. (7)]

5. The MOHLTC ACTIONLine received a complaint on an identified date, log #022257-17, related to insufficient staffing that compromised the timely provision of resident #042's care.

During observations on three different identified dates, it was noted that resident #042 had contact precautions signage posted on their door. Interviews with PSW #131, RPN #152, and ADOC #102 confirmed that the resident had an identified medical condition and that staff were required to wear gloves and gown when providing direct care for hygiene.

During an observation on an identified date and time, resident #042 was toileted by two PSWs in the tub room. The two PSWs applied a hygiene sling on resident #042, and used the identified equipment to transfer the resident from their personal device onto the toilet. The resident was provided the identified care and they were transferred back to their personal device. Both PSWs only donned on gloves and did not put on a gown, when they provided direct care to resident #042.

Interviews with PSW #132 and RPN #152 acknowledged that resident #042 had the contact precautions signage posted on their door, and directed staff to use gloves and gown when providing direct care for hygiene. PSW #132 acknowledged that care had not been provided to the resident as specified in the plan, as the PSWs did not put on a gown when they provided direct care to the resident.

Interview with ADOC #102 acknowledged that care had not been provided to the resident as specified in the plan, and that the home's expectation was for the PSWs to follow the required contact precautions when providing direct care for hygiene to resident #042. [s. 6. (7)]

6. The MOHLTC ACTIONLine received anonymous complaints on an identified date, log #026880-17, and on another identified date, log #s: 026878-17, 026879-17, 026883-17, related to insufficient staffing that resulted in the following:

-Residents stay in bed and get breakfast around 0930 hrs or 1000 hrs. The residents are not provided care for during the night shift with the day shift staff unable to provide care to them until 1000 hrs. Medications are distributed off schedule and late in the mornings.

During the Resident Quality Inspection (RQI), the inspector conducted observations, interviews, and record reviews, to determine any staffing issues in the home.

A) Staff interview indicated that the breakfast meal service in an identified home area commenced at an identified time. Observations conducted in an identified home area on an identified date and time, revealed 23 residents were present in the dining room having their regular breakfast meal. During rounds an hour and a half later, the inspector found residents #035, #037, #038, and #040, in bed.

Review of the the above mentioned residents' written plan of care indicated they preferred to get up at an identified time.

Interviews with PSWs #108, #109 and RPN #110, stated they were behind with morning care because they were short one regular PSW. The PSWs and the RPN stated they had to be in the dining room at an identified time, and had to leave the other residents in bed due to not having enough time to get them ready and take them to the dining room.

B) Observations conducted in an identified home area on an identified date and time, revealed 24 residents were present in the dining room having their regular breakfast meal. During rounds an hour and fifteen minutes following the breakfast meal service had commenced, the inspector found residents #035, #045, #046, and #047, in bed. Observations between an identified time period revealed the following:

-At three different identified times, residents #047, #035, and #045, were brought in the

dining room and received breakfast.
-At an identified time, resident #046 was still in bed.

Review of the the above mentioned residents' written plan of care indicated they preferred to get up at an identified time.

Interviews with the PSWs and the RPN stated they were short one regular PSW, and were behind with morning care and unable to bring the above mentioned residents in the dining room for the breakfast meal service. The staff further acknowledged that they were unable to get them up at the residents' preferred time as per their written plan of care.

Interview with the DOC acknowledged the above mentioned information and further indicated that care had not been provided to the residents as specified in their written plan of care. [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 the following
-that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident;
-that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other;
-that 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

On an identified date, the home submitted a CIS report to the Director, reporting an incident of resident to resident abuse. The report read as follows:

On an identified date and time, in an identified home area, a housekeeping staff saw resident #022 exhibit an identified responsive behaviour toward resident #024, while sitting on a chair in the corner of the TV lounge, while waiting for snacks and drink. The residents were separated.

Resident #022 was admitted to the home with an identified list of admitting diagnoses. Review of resident #022's admission record indicated that behavioural assessments provided to the home by the Community Care Access Centre (CCAC) on two identified dates, indicated resident #022 displayed inappropriate behaviour towards residents and staff in an identified manner.

Review of resident #024's health record and interviews held with NM #104 and the DOC indicated that resident #024 had a Cognitive Performance Scale (CPS) score of 6 and would not have had the capacity to consent to engage in identified behaviours.

A review of the home's investigation notes indicated that the Substitute Decision-Maker (SDM), medical director, and police were notified of the incident. One on one monitoring was initiated for both residents #022 and #024. Review of resident #024's health records and interviews held with RN #149, RPN #150 and PSW #151 indicated that upon the incident being reported to them, a head to toe assessment was completed and resident #024 did not display any signs of distress.

Review of progress notes upon admission up to an identified date, indicated that resident #022 initially displayed inappropriate behaviours towards a resident and visitor on the identified date, and towards staff members on two identified dates. The written plan of

care was not initiated and/ or revised until after the incidents had occurred, identifying the resident's inappropriate behaviours.

Between an identified time period, there had been seven incidents of inappropriate behaviours towards residents and numerous incidents made towards staff members of a specific gender.

On an identified date, a subsequent incident of inappropriate behaviour was displayed by resident #022. Resident #022 approached co-resident #023 in their own room and made an inappropriate statement. Resident #023 was cognitively intact and expressed to inspector #116 during an interview that the statements made by resident #022 made them feel more like an object rather than a human being.

An interview held with RPN #130 indicated having knowledge of resident #022’s inappropriate behaviours and the interventions in place to minimize the behaviours. RPN #130 indicated that resident #023 brought forward the concerns to them, however, the RPN did not address the incident with resident #022 nor did the staff member reinforce the intervention to inform resident #022 that the behaviour was inappropriate as the incident was not witnessed.

Internal and external referrals were made by the licensee, among them were the home’s attending physician, BSO team and most recently LOFT. One on one monitoring was initiated for residents #022 and #024, after the incident occurred on an identified date. Among many other interventions such as encouraging resident #022 to join more activities on and off the unit, assigning PSWs of identified gender to provide care if available, separating resident from co-resident when the other appears to be the trigger of the behaviour, avoid seating resident next to co-residents of an identified gender, in common areas or during programs and transferring resident #022 from units where residents have been exposed to resident #022's inappropriate behaviour. Despite the implemented interventions to address, resident #022 continues to display inappropriate behaviours .

Interviews held with the DOC and the ED confirmed that the behaviours displayed by resident #022 towards residents #023 and #024, fall under the home's definition of abuse. Further interview held with the DOC confirmed that the home had failed to protect residents #023 and #024 from abuse. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

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

Findings/Faits saillants :

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

On an identified date, the home submitted a CIS report to the Director, reporting an incident of resident to resident abuse. The report read as follows:

On an identified date and time, on an identified home area, a housekeeping staff saw resident #022 exhibit an identified responsive behaviour toward resident #024, while sitting on a chair in the corner of the TV lounge, while waiting for snacks and drink. The

residents were separated.

Review of resident #022's written plan of care initiated on an identified date, indicated that the resident displayed inappropriate behaviour towards residents and staff. One of the interventions in place to minimize the incidents of inappropriate behaviour, directed staff to reinforce the following: If resident #022 made any inappropriate comments or exhibit the identified behaviour toward others and staff, they should respond with the identified statement.

Review of progress notes upon admission up to an identified date, indicated that resident #022 initially displayed inappropriate behaviours towards a resident and visitor on the identified date, and towards staff members on two identified dates. The written plan of care was not initiated and/ or revised until after the incidents had occurred, identifying the resident's inappropriate behaviours.

Further review of resident #022's progress notes revealed subsequent incidents of inappropriate behaviours to staff and other residents.

On an identified date, a subsequent incident of inappropriate behaviour was displayed by resident #022. Resident #022 approached co-resident #023 in their own room and made an inappropriate statement. Resident #023 was cognitively intact and expressed to inspector #116 during an interview that the statements made by resident #022 made them feel more like an object rather than a human being.

Interviews held with BSO nurses #146, #147 and the DOC indicated being aware of resident #022's inappropriate behaviours. The DOC stated that resident #022 was transferred to another room within another unit and one on one monitoring was initiated for residents #022 and #024, after the incident occurred on an identified date. The BSO nurse indicated that the Dementia Observation System (DOS) monitoring was implemented for an identified date, after the incident between residents #022 and #023 had occurred. As of an identified date, the DOC and the BSO team had not determined whether resident #022 would remain on DOS monitoring and remain within the private room.

Despite the implemented interventions to address resident #022's inappropriate behaviours, they were found to be ineffective as resident #022 continues to display inappropriate behaviours .

Further interview held with the DOC confirmed that the licensee failed to ensure that procedures and interventions had been developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and amongst residents. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a system in place to measure and record, with respect to each resident, body mass index and height upon admission and annually thereafter.

During stage one of the RQI, residents #008, #009, and #010 were identified with missing heights for 2017, during their census record review.

Review of resident clinical records identified no annual height had been documented for the identified residents.

Interview with the home's RD confirmed that residents required annual height measurements to ensure accuracy of assessment and Body Mass Index (BMI) determinations. Record review of the identified residents with the home's RD confirmed no heights had been completed for residents #008, #009, and #010 in 2017. The RD acknowledged the legislative requirement for annual height monitoring was not met.

Interview with the DOC acknowledged the identified residents above did not have annual heights completed for 2017, and that the home had failed to meet the legislative requirement for annual height monitoring. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident, body mass index, and height upon admission and annually thereafter, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

The MOHLTC ACTIONLine received anonymous complaints on an identified date, log #026880-17, and on another identified date, log #s: 026878-17, 026879-17, 026883-17, related to insufficient staffing that resulted in the following:

-Residents stay in bed and get breakfast around 0930 hrs or 1000 hrs.

Review of the home's four week cycle menu and the daily menu posted in an identified home area indicated the breakfast menu on an identified date, consisted of stewed prunes, cream of wheat, sausage patty on biscuit or banana, assorted cold cereal, peanut butter, and whole wheat toast.

During the breakfast meal service observation on an identified date and time, it was noted that the stewed prunes were not being offered to the residents. Upon checking the servery area, no stewed prunes were seen available.

During an interview, the inspector reviewed the posted menu with Dietary Aide (DA) #124 , and asked to confirm if the DA had the stewed prunes in the servery. The DA reviewed the posted menu, and realized that the stewed prunes were listed under the breakfast menu. The DA stated they did not have the stewed prunes in the servery, but assured the inspector they had it in the main kitchen. The DA further confirmed that the planned menu item was not offered and available at the breakfast meal.

Interview with the Director of Dietary Services (DDS) acknowledged the above mentioned information and confirmed that the expectation was for the planned menu items to be offered and available at each meal and snack. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of three meals daily, and that planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On an identified date and time, during the initial walkthrough of the home, inspector #116 entered an identified unit and observed the medication cart stored in the hallway to be left unlocked and unattended. RPN #116 who was assigned to the medication cart was noted to be seated in the nursing station with their back facing the cart while on the telephone.

Inspector #116 was able to access the contents of the medication cart for a period of approximately three minutes without the staff member being aware of their presence. Residents were observed in the TV lounge which was adjacent to the medication cart and within close proximity. Upon terminating the phone call, RPN #116 approached the medication cart and acknowledged that the cart should be locked at all times when unattended.

Further interview held with the ED confirmed that the medication carts were to be locked at all times when not in use. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #7: 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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The MOHLTC ACTIONLine received anonymous complaints on an identified date, log #s: 026878-17, 026879-17, related to insufficient staffing that resulted in medications being administered off schedule and late in the mornings.

Staff interview confirmed that the lunch meal service in an identified unit commenced at an identified time. During an observation in the identified unit on an identified date and time, NM #104 was noted to administer medications to residents #030, #039, #031, and #032.

-Review of resident #030's electronic Medication Administration Record (eMAR) and physician orders from an identified date, revealed an identified intervention and medication administration to be provided at an identified time. At an identified time, NM #104 performed the intervention and administered the medication to the above mentioned resident not at the specified time.

-Review of resident #039's eMAR and physician orders from an identified date, revealed they were to receive an identified oral medication at an identified time. At an identified time, NM #104 administered the medication to resident #039, not at the specified time.

-Review of resident #031's eMAR and physician orders from an identified date, revealed they were to receive an identified medication at an identified time. At an identified time, NM #104 administered the identified medication to the resident, not at the specified time.

-Review of resident #032's eMAR and physician orders from an identified date, revealed they were to receive an identified medication at an identified time. NM #104 administered the time specific medication to the resident, not at the specified time.

Interview with NM #104 revealed they do not normally work on the floor, but was called in because the unit did not have an RPN for the day shift. The night shift RPN stayed until 1030 hrs, and then NM #104 took over the unit. The NM further indicated they were not used to working in the identified home area. NM #104 confirmed they were behind with the lunch medication pass, and that the above mentioned residents did not receive their medications on time in accordance with the directions for use specified by the prescriber.

Interview with the DOC acknowledged the above mentioned observations, and indicated that the home's expectation was to administer medications to the residents according to best practice guidelines and at the directions for use specified by the prescriber. [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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: 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 has failed to ensure that staff participated in the implementation of the infection prevention and control program.

On an identified date and time, inspector #116 entered an identified unit, and observed PSW #114 exit from an identified room wearing gloves. Signage posted on the door of the room indicated that contact precautions were in place. The identified room was noted to be equipped with Personal Protective Equipment (PPE) and an isolation cart.

PSW #114 was noted to be transporting a mechanical lift that was used in the identified room throughout the hallway while still wearing the gloves. A resident was observed sitting in the dining room which was located beside the identified room and was fidgeting with a beverage cup, with the cover and straw detached from the cup, and contents exposed. PSW #114 was observed to attend to the resident and handled the cup and

contents while wearing the same gloves.

An interview held with PSW #114 indicated that they transferred the resident in the identified room, to bed while in the room.

An interview held PSW #114 and RN #115 indicated that the identified room was under contact precautions due to a medical condition which required the use of PPE for all care and services rendered to the resident. Further interviews held with both staff indicated that PPE should be donned upon entry to a room where contact precautions were in place and removed prior to exiting the area.

Review of the home's Infection Prevention and Control (IPAC) Manual identified the following policies and procedures:
Policy titled "Use of Gloves" (# IX-G-10.30, January 2015) indicated the following:
-All staff will not use the same pair of gloves for the care of more than one resident.
-Remove gloves immediately and discard after the activity for which they were used, then perform hand hygiene.

Policy titled "Hand Hygiene" (# IX-G-10.10, April 2016) indicated the following:
-All members (of the home's care team) will practice hand hygiene according to the four moments of hand hygiene which include before and after initial resident environmental contact.
-Practices include before and after entering and leaving work area.

Interview with ADOC #102 confirmed that the identified room was under contact precautions for an identified medical condition. ADOC #102 confirmed that all front line staff were expected to follow the home's IPAC policies and procedures as reviewed in the polices noted above. The ADOC further acknowledged failure of staff to implement the home's IPAC policies and procedures as noted in observations made by inspector #116. [s. 229. (4)]

2. The MOHLTC ACTIONLine received a complaint on an identified date, log #022257-17, related to insufficient staffing that compromised the timely provision of resident #042's care.

During observations on three different identified dates, it was noted that resident #042 had contact precautions signage posted on their door. Interviews with PSW #131, RPN #152, and ADOC #102 confirmed that the resident had an identified medical condition

and that staff were required to wear gloves and gown when providing direct care for hygiene.

During an observation on an identified date and time, resident #042 was toileted by two PSWs in the tub room. The two PSWs applied resident #065's hygiene sling on resident #042, and used the identified equipment to transfer the resident from their personal device onto the toilet. The resident was provided the identified care and they were transferred back to their personal device. Both PSWs only donned on gloves and did not put on a gown, when they provided direct care to resident #042.

Interview with PSW #132 when asked to confirm if the hygiene sling used was resident #042's, the PSW stated that the hygiene sling belonged to resident #065. PSW #132 also stated they were uncertain whether the resident still required the use of complete PPE when being provided care to, because it had been a long time since the resident had the contact precautions signage posted on their door, and queried whether it was just not taken down.

Interview with ADOC #102 acknowledged the above mentioned observation and confirmed that the PPE required for contact precautions were gown and gloves, when providing direct care for hygiene. The ADOC further indicated that there was no communal sling and each resident was to have their own sling. ADOC #102 acknowledged that the staff did not participate in the implementation of the IPAC program in the home. [s. 229. (4)]

Additional Required Actions:

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 17th day of April, 2018

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

Original report signed by the inspector.