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 # / Registre no	Type of Inspection / Genre d'inspection
Jan 10, 2017	2016_323130_0021	031620-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA
155 PANIN ROAD BURLINGTON ON L7P 5A6

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

CAMA WOODLANDS NURSING HOME
159 PANIN ROAD BURLINGTON ON L7P 5A6

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

GILLIAN TRACEY (130), CATHY FEDIASH (214), HEATHER PRESTON (640)

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): November 14, 15, 16, 17, 21, 22, 23, 24, 2016.

Please note: Inspector Debora Saville #192 participated in this inspection. During this inspection, staff, residents, families, President of Residents' Council, President of Family Council were interviewed, clinical records and relevant policies and procedures were reviewed and residents were observed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, registered staff, personal support workers (PSWs), Food Services Supervisor (FSS), Building Services Manager, President of Residents' Council, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **5 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 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 was complied with.

A) The home's policy titled: Weighing Residents, 05-02-07, directed the "Restorative Care Aide/Health Care Aide to weigh residents monthly during the first week of every month (or more frequently as required) and record in Point Click Care (PCC); the Food Service Supervisor (FSS) is to print 1, 3 and 6-month weight records and compare all measurements to previous months and if the measurements to previous months appear questionable, ask for a re-weigh of the resident; the FSS will report the significant weight change to the Charge Nurse who will report to the Physician; residents with significant weight changes are discussed with the Dietician to determine if nutrition priority ranking is to be changed and developed and interventions care planned".

i) Resident #207's recorded weight in 2016 indicated a significant weight loss over a one month period. There was no recorded re-weigh documented.
The DOC confirmed that a 5% weight loss or gain over a one month period would be considered significant and would require a re-weigh.

ii) Resident #205's recorded weight in 2016, indicated a significant weight loss over one month. There was no recorded re-weigh documented.

The DOC confirmed that resident #205 and #207 were not re-weighed.

The home's policy titled: Weighing Residents, 05-02-07, was not complied with. (Inspector #130).

B) The home’s policy titled Retrieval of Lost Items, Number BS-6-11 and effective February 2016, directed staff to fill out a form identifying the item lost and post it outside the laundry room on the "Lost Items" board to inform staff.

i) On an identified date in 2016, RPN #160 received a complaint from resident #401's family member who stated there were articles of clothing brought in to the home and only two articles found. An interview with the Building Services Manager confirmed there was no form completed of the missing laundry and that it was the expectation of the home that a form be completed and posted. (Inspector #640).

C) The home's policy titled: Residents' Rights, 02-03-02, revised January 2014, indicated "CAMA Woodlands Nursing Home is committed to ensuring that each resident: 1. has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity".

i) On an identified date in 2016, resident #600's Substitute Decision Maker (SDM) witnessed staff #177, hit resident #600. The incident did not result in injury to the resident; however, the DOC confirmed staff #177 did not treat resident #600 with courtesy or respect.

The DOC confirmed the home's policy titled: Residents' Rights, 02-03-02, revised January 2014, was not complied with.

Please note: This area of non-compliance was identified during a concurrent inspection #031261-15, related to staff to resident abuse. (Inspector #130). [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with r. 50. (2) which requires every licensee of a long-term care home to ensure that, a resident is assessed by a registered dietitian who is a member of the staff of the home, and that any changes made to the resident’s plan of care relating to nutrition and hydration are implemented.

A) The home’s policy titled Skin Care Program, 07-02-04, identified steps to be taken when a break in skin integrity was detected; however, the policy did not identify steps to be taken when a resident exhibited any altered skin integrity, including skin breakdown,

pressure ulcers, skin tears or wounds nor did it indicate that the resident with altered skin integrity would be assessed by a registered dietitian who was a member of the staff of the home, and that any changes made to the resident's plan of care relating to nutrition and hydration would be implemented.

The DOC confirmed the home's policy titled Skin Care Program, 07-02-04 was not in compliance with applicable requirements under the Act and in accordance with r. 50. (2). (Inspector #130). [s. 8. (1) (a),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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and implemented in accordance with applicable requirements under the Act and complied with, 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 failed to protect residents from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

A) A Critical Incident submitted in 2016, identified that resident #500 was the recipient of an identified responsive behavioiur by resident #501 on a specified date in 2016.

Interview with resident #500 confirmed that the incident had occurred involving resident #501 and that at the time of the incident they felt scared.

Record review identified that resident #501 had demonstrated a similar responsive behaviour towards three co-residents prior to the reported incident in 2016.

During interview with registered staff #143, following review of the plan of care for resident #501, they stated they had initiated interventions related to the responsive behaviour demonstrated towards co-residents in the home area, following the reported incident in 2016; however, no interventions had been put in place prior to the reported incident in 2016.

Interview with the DOC identified that it would be their expectation that the documented incidents of responsive behaviour demonstrated by resident #501 would be require interventions to protect other residents that should have been initiated when the responsive behaviour was first identified in 2016

The licensee failed to protect resident #500 from responsive behaviours when interventions were not initiated following known incidents of the responsive behaviours demonstrated by resident #501.

Please note: This area of non-compliance was identified during a concurrent Critical Incident Inspection 031663-16 related to resident to resident abuse. (Inspector #192). [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 residents are protected from abuse and 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's drugs and treatments.

A) On an identified date in 2016, resident #206 was observed to have impaired skin integrity to two specified areas An interview with the resident confirmed that the affected areas were as a result of a treatment.

A review of the resident's progress notes over a two week period in 2016, as well as assessment's in point click care (PCC) indicated that no documentation had been completed that identified the affected areas.

A review of the resident's electronic medication administration record (eMAR) indicated that the resident was receiving an anitcoagulant routinely. The eMAR indicated that the resident had been prescribed this medication since 2014.

A review of the resident's current written care plan did not identify this medication or any

safety risks associated with taking this medication, including the risk of impaired skin integrity.

An interview with registered staff #166 confirmed that the resident was currently taking this medication and that the plan of care had not been based on an assessment of this drug. (Inspector #214) [s. 26. (3) 17.]

2. The licensee failed to ensure a plan of care was based on, at a minimum, interdisciplinary assessment of the resident including, (3) 21. Sleep patterns and preferences.

A) During the Stage One interview, resident #200 stated that at times they were still in bed at a specified time and that this was not acceptable. A review of the clinical record, including the written plan of care, kardex, progress notes, minimum data set (MDS) assessments in PCC revealed there was no interdisciplinary assessment or documentation of resident #200's sleep patterns and preferences. An interview with PSW #136 confirmed resident #200's sleep patterns and preferences were not included in the Kardex. An interview with RPN #166 confirmed there was no interdisciplinary assessment or documentation in resident #200's plan of care for sleep patterns and preferences. The RAI Coordinator confirmed there was no interdisciplinary assessment or documentation in the plan of care of resident #200's sleep patterns and preferences. The Clinical Manager confirmed there was no interdisciplinary assessment or documentation in the plan of care of resident #200's sleep patterns and preferences. The DOC confirmed resident #200 did not have an interdisciplinary assessment and documentation of sleep patterns and preferences on the plan of care and there was no clear direction to staff to assess and document the resident's sleep patterns and preferences in the plan of care. The plan of care did not include an interdisciplinary assessment of the resident's sleep patterns and preferences. (Inspector #640).

B) During the Stage One interview, resident #203 stated at times they were assisted out of bed in the morning prior to their time of preference and this was not acceptable. Review of the clinical record, written plan of care, the kardex, progress notes, MDS and assessments in PCC revealed there was no interdisciplinary assessment or documentation of resident #203's sleep patterns and preferences. PSW #136 confirmed resident #203's sleep patterns and preferences were not included in the Kardex. Registered staff #166 confirmed there was no interdisciplinary assessment or documentation in resident #203's plan of care for sleep patterns and preferences. The RAI Coordinator confirmed there was no interdisciplinary assessment or documentation

in the plan of care of resident #203's sleep patterns and preferences. The Clinical Manager confirmed there was no interdisciplinary assessment or documentation in the plan of care of resident #203's sleep patterns and preferences. The DOC confirmed resident #203 did not have an interdisciplinary assessment and documentation of sleep patterns and preferences in the plan of care and there was no clear direction to staff to assess and document the resident's sleep patterns and preferences in the plan of care. The plan of care did not include an interdisciplinary assessment of the resident's sleep patterns and preferences. (Inspector #640). [s. 26. (3) 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment of the resident's drugs treatments, sleep patterns and preferences, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

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

A) Resident #200 was admitted 2016. A Braden Scale Risk Assessment completed on a specified date in 2016, identified the resident to be at moderate risk of skin breakdown. The record review revealed a "head-to-toe" skin assessment was completed by a

registered nursing staff, four days after admission. An interview with the DOC confirmed the assessment was not completed within 24 hours of admission.

The licensee failed to complete a skin assessment of resident #200 within 24 hours of admission. (Inspector #640). [s. 50. (2) (a) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) According to the "skin/wound" progress notes, resident #204 had identified alterations in skin integrity on three occasions in 2016. The DOC confirmed that the resident did not have a skin assessment completed for the identified areas on the identified dates, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (Inspector #130). [s. 50. (2) (b) (i)]

3. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who was a member of the staff of the home.

A) A review of resident #206's annual assessment coding in MDS dated in 2016, indicated that the resident was coded as having an area of impaired skin integrity. A review of the resident's current written care plan identified that the area of impaired skin integrity was healing.

An interview with the DOC confirmed that the impaired skin integrity was sustained from a fall on an identified date in 2016 and was still present. The DOC confirmed that referrals to the RD were supposed to be initiated by the nursing department through an electronic referral completed in PCC and that no referrals had been sent to the RD for resident #206's alteration in their skin integrity. (Inspector #214). [s. 50. (2) (b) (iii)]

4. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #204 had identified alterations in skin on three identified dates in 2016. The DRC confirmed that skin assessments were not completed weekly for the identified

areas, while treatment and ongoing monitoring of the affected areas was required. (Inspector #130).

B) During a review of resident #200 clinical record, it revealed that weekly skin assessments were not completed by registered nursing staff. At the time of resident #200's in 2016, the resident's spouse had informed registered staff that the resident had a skin concern to a specified area. On a later date in 2016, the "head to toe" skin assessment was completed which revealed two areas of impaired skin integrity to a specified area. The next documented assessment of the affected area which was completed shortly after, indicated the area had healed. An initial assessment of the affected area completed on a date in 2016. Twenty days later there was a progress note that stated the area was "clear" and "skin assessment done". A skin assessment was completed days after that and revealed the affected area was not healed, but improving and to continue with the same treatment. Policy, Skin Care Program, Document Number 07-02-04, and revised February 2014, directed the Skin Care Coordinator to complete a weekly wound assessment on all wounds using the "Weekly Assessment" tool in PCC. The DOC confirmed the documented areas should have had weekly assessments completed and that weekly assessments were not done.

The licensee failed to ensure that weekly skin assessments were completed for altered skin integrity. (Inspector #640).

C) A review of resident #206's annual assessment coding in MDS dated in 2016, indicated that the resident was coded as having an area of impaired skin integrity. A review of the resident's current written care plan identified that the area of impaired skin integrity was healing.

A review of the assessment's in PCC titled, "Wound Assessment 2", as well as progress notes over a three month period in 2016, indicated that weekly wound assessments of the resident's affected area had not been completed each week for the time period reviewed. An interview with the DOC, confirmed that the resident's affected area was sustained from a fall earlier in 2016 and that for the time period reviewed, weekly wound assessments had not been completed on an identified month in 2016 and had not been completed for two identified weeks 2016. The DOC confirmed that the affected areas were not reassessed at least weekly by a member of the registered nursing staff. (Inspector #214). [s. 50. (2) (b) (iv)]

5. The licensee has failed to ensure the resident who was dependent on staff for

repositioning was repositioned every two hours.

A) Review of the clinical record revealed the written plan of care and kardex, directed staff to turn resident #200 every two hours while in bed. A review of the POC documentation, identified no task directing staff to turn the resident every two hours. PSW #067, confirmed staff do not routinely turn resident #200 every two hours and confirmed there was no task in POC to turn or reposition resident every two hours while in bed. The DOC confirmed staff were expected to document turning and repositioning in POC and resident #200 was to be turned or repositioned every two hours while in bed. The DOC confirmed the resident was not turned or repositioned every two hours while in bed.

The licensee failed to ensure the resident who was dependent on staff for repositioning was repositioned every two hours. (Inspector #640). [s. 50. (2) (d)]

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 receive a skin assessment by a member of the registered nursing staff within 24 hours of admission; to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home; to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated and to ensure the resident who is dependent on staff for repositioning is repositioned every two hours, to be implemented voluntarily.

WN #5: 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 failed to ensure that every residents' height was assessed upon admission and annually thereafter.

A) During the Stage One Census Record review it was noted that not all residents had their height measured annually.

The DOC confirmed that all residents' heights were assessed on admission only and not on an annual basis. (Inspector #130). [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 every resident's height is assessed upon admission and annually thereafter, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A) The licensee's policy titled Abuse Policy, document number 05-01-01 dated as revised June 2016, stated under procedure;

- Any employee, volunteer or resident witnessing an alleged, actual act of abuse or becoming aware of one would immediately report it to the Supervisor or Delegate;
- The Supervisor/Delegate would ensure that the emergency needs of the resident had been met;
- The Physician would be immediately notified and would conduct a medical assessment of the condition of the residents involved;
- The Administrator or delegate would notify the MOHLTC (Ministry of Health and Long Term Care) immediately by telephone;
- A critical incident report would be completed and submitted on line within 10 days. As soon as the supervisor/delegate was made aware of an alleged/actual abuse, an investigation would be conducted immediately;
- All witnesses would be interviewed and the facts documented;
- A detailed description of the incident was to be documented on the resident's charts that clearly described the incident. The documentation was to outline the physical findings and the care and treatment provided to all involved;
- Both residents' families were to be notified regarding the incident;
- The police would be notified; and
- The health care team would review the abusers care plan and review interventions in the care plan to deal with aggressive behaviour, updating and adapting as necessary. Interventions would be monitored by the health care team for effectiveness.

A Critical Incident submitted on an identified date in 2016, identified that resident #500 was the recipient of a responsive behaviour by resident #501 on a specified date in 2016. Record review identified that resident #501 had demonstrated a responsive behaviour towards three co-residents prior to the reported incident in 2016.

During an interview with the DOC, she stated she was not aware of at least three known incidents in 2016, involving resident #501, nor the incident involving resident #500. The DOC also stated that none of the incidents had been reported to the MOHLTC, as she was the person responsible for completing Critical Incidents for the home. The DOC stated that she would have expected registered staff responsible for the residents, at the time of the incidents, to have communicated the incidents to her through the internal incident reporting system, email, voice mail, text or verbally and confirmed that had not occurred for any of these incidents.

Review of the medical record failed to identify that the physician had been notified of resident #501's responsive behaviour until after the last incident in 2016, when an order for assessment by the Behaviour Supports Ontario (BSO) team and Halton Geriatric Mental Health Outreach Program was recorded. There was no documentation of the family of resident #501 being notified of the incidents nor record of the police being notified.

Interview with registered staff #143 confirmed that interventions in the plan of care related to the responsive behaviour towards co-residents were not initiated until later in 2016, despite three previously known incidents. Registered staff #143 stated they were not aware of any of the three prior incidents and confirmed that two of the three incidents failed to identify the residents who were the recipient of responsive behaviours demonstrated by resident #501.

The licensee failed to ensure that the Abuse Policy was complied with.

Please note: This area of non-compliance was identified during concurrent Critical Incident Inspection 031663-16 related to resident to resident abuse. (Inspector #192).

B) On an identified date in 2016, resident #600's Substitute Decision Maker (SDM) witnessed staff #177, hit resident #600. The home's investigation notes confirmed the resident was assessed by registered staff #150, upon learning of the incident; however, a detailed description of the incident nor the physical findings, care and treatment provided

to the resident were documented in the resident's clinical record.

The DOC confirmed the home's policy titled: Abuse Policy, 05-01-01, revised June 2016, was not complied with. (Inspector #130).

Please note: This area of non-compliance was identified during a concurrent inspection #031261-15, related to staff to resident abuse. (Inspector #130). [s. 20. (1)]

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:
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the 24 hour admission care plan included, at a minimum, skin condition, including interventions.

A) Resident #200 was admitted in 2016. Review of the clinical record revealed a Braden Scale Risk Assessment completed after their admission, assessed the resident at moderate risk for skin breakdown. The 24 hour admission care plan, MDS 24 hour Initial Admission Assessment, completed after admission, did not include any interventions to maintain skin integrity and prevent skin breakdown. The Clinical Manager confirmed the MDS 24 hour Initial Admission Assessment was the 24 hour admission care plan and the plan was expected to include interventions. The Clinical Manager confirmed resident #200's, 24 hour initial care plan did not include any interventions related to skin integrity to prevent skin breakdown.

The licensee failed to ensure the initial 24 hour care plan included interventions to maintain skin integrity and prevent skin breakdown. (Inspector #640). [s. 24. (2) 7.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the
method of choice.

A) On an identified date in 2016, resident #200's spouse complained to registered staff #174 that resident did not receive shower/bath on the previous day. A week later, resident #200 complained to registered staff #161, that they did not receive a shower/bath the previous day. Review of the clinical record revealed that resident did not receive their bi-weekly shower/bath between over at least two identified weeks in 2016. An interview with the DOC by Inspector #192, confirmed that bi-weekly bathing was not reflected for the identified dates.

The licensee failed to ensure that the resident was bathed, at a minimum, twice a week. (Inspector #640). [s. 33. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required it.

A) The Quarterly MDS Assessment completed for resident # 203, on a specified date in 2016, indicated in the coding that the resident was frequently incontinent of bladder. The Quarterly MDS assessment completed the next quarter 2016, indicated in the coding that the resident was incontinent of bladder most or all of the time, which indicated a a worsening in bladder incontinence.

The DOC was interviewed confirmed that a continence assessment using a clinically appropriate assessment instrument specifically designed for continence was not completed when there was a change in resident #203's continence. (Inspector #130). [s. 51. (2) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible.

A) The home reported a Critical Incident on an identified date in 2016, that resident #500 was the recipient of a responsive behaviour by resident #501.

Review of the medical record for resident #501 identified there were prior incidents involving three co-residents on the home area in 2016.

Review of the plan of care identified that interventions had been initiated in relation to responsive behaviour of non-consensual sexual touching following the last incident and that no interventions had been in place prior to the last incident in 2016. Interview with registered staff #143 confirmed that they had initiated the responsive behaviour plan of care after the last known incident.

Interview with the DOC confirmed that staff documenting the three prior incidents in 2016, by resident #501, had not reported the incidents so that an investigation could be initiated and that interventions were not initiated on the plan of care for resident #501 until after the last known incident in 2016.

The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

Please note: This area of non-compliance was identified during concurrent Critical Incident Inspection 031663-16, related to resident to resident abuse. (Inspector r#192). [s. 53. (4) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure a medication cart was secure and locked.

A) During noon medication pass observation by Inspector, November 21, 2016, registered staff #157 left the medication cart unlocked and unsupervised on two occasions, outside of the dining room entrance, while in the dining room administering medication to a resident. Registered staff #157 confirmed this practice was unsafe. The DOC confirmed the practice to be unsafe and the expectation was that staff kept the medication cart locked at all times when the cart was not supervised or stored in a secure area.

The licensee failed to ensure a medication cart was secure and locked. (Inspector #640). [s. 129. (1) (a)]

WN #12: 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 participated in the implementation of the infection prevention and control program.

A) During a tour of the home on November 14, 2016, the following was observed:

- Oakwood Unit bathing suite: a cup on a table beside the bathtub contained an unlabelled pink comb, brush and toe nail clippers. The brush was noted to have strands of hair within the bristles.
- Oakwood Unit shower suite: an unlabelled roll on deodorant was observed on the counter.

An interview with registered staff #143 confirmed that personal items were to be used for individual residents and labelled with residents' names and that as a result of the items found, not all staff had participated in the infection prevention and control program. (Inspector #214). [s. 229. (4)]

Issued on this 22nd day of February, 2017

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

Original report signed by the inspector.