Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 4, 2018	2018_606563_0005	002000-18	Resident Quality Inspection

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care on Bonnie Place
15 Bonnie Place St Thomas ON N5R 5T8

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

MELANIE NORTHEY (563), AMIE GIBBS-WARD (630), INA REYNOLDS (524)

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 12, 13, 14, 15, 16, 20, 21, 22, 23, 26, and 28, and March 1 and 2, 2017

The following intakes were completed within the Resident Quality Inspection (RQI):
010271-17 - Follow up inspection to Compliance Order #001 from RQI #2017_263524_0005 related to medication administration,
008147-17 - IL-50485-LO - Complaint related to staff to resident suspected abuse and medication incidents
017565-17 - Complaint related to resident to resident suspected abuse and

responsive behaviours
011553-17 - IL-51274-LO - Complaint related to housekeeping
021865-17 - IL-52887-LO - Complaint related to dignity and choice
006778-17 - 2730-000011-17 - Critical Incident related to staff to resident suspected abuse
017143-17 - 2730-000023-17 - Critical Incident related to staff to resident suspected neglect
018142-17 - 2730-000024-17 - Critical Incident related to staff to resident suspected abuse
025265-17 - 2730-000038-17 - Critical Incident related to staff to resident suspected abuse
021034-17 - 2730-000030-17 - Critical Incident related to dignity and choice
010582-17 - 2730-000019-17 - Critical Incident related to staff to resident suspected abuse
002950-17 - 2730-000004-17 - Critical Incident related to staff to resident suspected abuse
004251-17 - 2730-000006-17 - Critical Incident related to staff to resident suspected abuse
006361-17 - 2730-000009-17 - Critical Incident related to staff to resident suspected abuse
007313-17 - 2730-000013-17 - Critical Incident related to a fall
007737-17 - 2730-000014-17 - Critical Incident related to a fall
022421-17 - 2730-000033-17 - Critical Incident related to a fall
008149-17 - 2730-000015-17 - Critical Incident related to a fall
003509-18 - 2730-000005-18 - Critical Incident related to staff to resident suspected abuse

Inspector: Cassandra Aleksic (689) assisted with the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Resident Care Coordinator, Resident Instrument Assessment Coordinators, the Food and Nutrition Manager, the Cook, the Clinical Consultant Pharmacist,the Physiotherapist, the Physiotherapy Aide, the Activity Coordinator, the Behavioural Supports Ontario Registered Practical Nurse, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Housekeepers, Residents' Council President, Family Council Representative, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as medication incident reports, clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the procedures that had been developed as part of the organized program of housekeeping were implemented for cleaning floors, furnishings, and wall surfaces for resident bedroom and common areas.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint regarding the cleanliness of the home. This complainant reported that the housekeeping routines had been changed and that all rooms were going two weeks without being cleaned.

During an initial Resident Quality Inspection (RQI) tour of the home, Inspector found that common resident areas in the home were not kept clean. The following was observed:
- The Main Lounge had dirt and debris on the games table as well as dirt and spill marks

on the floor throughout the room and a build-up dust and cobwebs along the perimeter and in the corners of the floor.
- The hallway in front of the door leading to the outside courtyard (across from the Greenhouse room) had dirt and sand on the floor.
- The Chapel had spills on the wall above the garbage, dirt and dust build-up under the computer table, piano and cupboards as well as along the perimeter and in the corners of the floor.
- The lounge at the end of the C Wing had dirt on the floor throughout the room as well as white debris on the television stand.
- The Greenhouse Room had dirt and dust under the cupboard as well as along the perimeter and in the corners of the floor.

Observations of resident bedrooms during the RQI by multiple inspectors found that 17/26 (65 per cent) of the rooms were not kept clean. Resident bedrooms were observed to have dust and debris along the perimeters of the room, under beds and closets as well as in bathrooms.

The Family Council Meeting minutes were reviewed and it was found that they had expressed concerns regarding the cleanliness of the home. The meeting minutes included a concern that the raised toilets were not being cleaned. These minutes also included a concern regarding the cleaning of rooms, toilets not cleaned, floors having cobwebs in corners and sticky floors. These minutes also stated there were concerns about the dining room not being cleaned with stains on the walls and cobwebs by the doors. Other meeting minutes included a concern that the resident rooms and toilets were not being cleaned regularly. The Family Council documents also included a memo which stated that "deep cleaning schedules have been put into place and every room will be thoroughly cleaned. Housekeeping is to keep management informed of any issues that may arise and are required daily to submit an audit of work completed."

During an interview with two housekeepers, they said that they each cleaned approximately 20 resident rooms per day and said they would sign off on the schedule when they had completed the jobs and these were kept by the Administrator. They said that they are not always able to get their work done each day. They said that some of the build-up of dirt on the perimeter of the floors and walls were difficult to get during the day to day cleaning as they need to steam and scrape and so they tried to do that on the deep cleaning shifts.

The Administrator said they were the lead for the Housekeeping Program in the home.

The Administrator said that on a daily basis the resident rooms were to be cleaned, the garbages changed as well as the floors swept and mopped. They said there was also a deep cleaning routine that staff worked through which included the ledges, walls, curtains and behind the bed. They said that each room was to have a deep clean about every six months. The Administrator said they were unsure when the last deep clean for resident rooms had been done as these were being scheduled and monitored by the Director of Nursing (DON). The Administrator said that the common areas were assigned and cleaned on a weekly basis and at this time these were not completed as staff were assigned to other tasks. They said that the common areas were swept and mopped and at the time of the inspection they needed to work on the deep clean of these rooms. The Administrator said they had made revisions to the routines of the housekeepers and were continuing to make changes and revisions at the time of the inspection based on priorities that had been identified. The Administrator said that they did a “walk through” of the home daily and that they used the “Housekeeping Routine” sheets to monitor and audit.

The “Housekeeping Routine” sheets showed the following documentation of the "daily rotation schedule" for the common areas :
- The Chapel was not documented as having been cleaned three of six scheduled times (50 per cent).
- The Main Lounge was not documented as having been cleaned three of five scheduled times (60 per cent).
- The small lounge in the C Wing was not documented as having been cleaned one of two scheduled times (50 per cent).

The Director of Nursing (DON) said they were responsible for scheduling the deep cleaning of the resident rooms for the housekeeping staff. The DON said there were resident rooms that had not had a deep cleaning scheduled within the past six months. The DON said they used the audit forms to track the "Thorough Cleaning" that was completed for the past six months in the home.

The home’s “Housekeeping Audit” for all resident rooms showed that 32/51 (63 per cent) were documented as not having had a “Thorough Cleaning” completed in the past six months.

The home's "Common Area Housekeeping Audit" for the past six months, had eight of nine (89 per cent) areas not documented as having been completed.

The home's Housekeeping Department policy titled "Cleaning Guidelines – Thorough Cleaning" stated "all areas of the facility must be thoroughly cleaned as per schedule." This policy included the following procedure:
"Thorough cleaning: all daily cleaning items; stripping, re-waxing floors (if required) and buffering as per schedule; pull out furniture to clean behind; cleaning of inside windows; washing walls, ceilings (where possible); carbolozing of unit, including doors, closets, chest of drawers; removal of laundering of window curtains and privacy curtains (semi-annually or as per schedule); thorough dusting high and low; includes washroom area as well when cleaning resident's room."

Inspectors toured the Main Lounge, the small lounge, the Chapel and resident rooms with the Administrator. During this tour the Administrator said they would expect the common areas to be cleaner and that although they have been working to make improvements to the cleanliness of the home and revising the housekeeping routines they had to prioritize which areas would be the focus for cleaning in the home.The Administrator acknowledged that the floors in the common lounges were not clean and knew the Chapel had not been cleaned. The Administrator said that some of the areas in the resident rooms that were identified should have been cleaner. The Administrator said that the routines did not include the floor mats and said they would expect staff to know and clean if they were in place, but that floor mats needed to be added to the routines. The Administrator acknowledged that the "Housekeeping Routine" sheets showed that there were cleaning jobs that had not been documented as having been completed, for example the common areas. They said that there were days when they would pull the staff to do other tasks and the common areas would not have been clean, for example the Chapel, and there was some of the weekly cleaning that had not been done. The Administrator said they were not sure when the last time the deep cleaning was done of the common areas.

The DON told Inspectors that they had been doing the scheduling for the deep cleaning for the resident rooms and was planning on scheduling staff for the common areas starting next week. They said they were using the "Common Area Housekeeping Audit" for the deep cleaning of common areas and acknowledged there was no date or schedule for the areas to be done. The DON said that the large dining room was documented as having been done and thought that the small dining room had also been cleaned. The DON said that no other common areas had been scheduled or completed.

Based on these observations, interviews and record review it was found that there were areas of the home that were not kept clean. It was identified that there was no schedule

in place at the time of the inspection for the “thorough cleaning” of common areas and that the "thorough cleaning" of resident rooms had not been implemented as there were multiple rooms that had not had this completed in over six months. It was also identified that the procedures that had been developed as part of the organized program of housekeeping for cleaning resident rooms and common areas were not fully implemented. [s. 87. (2) (a)]

2. The licensee has failed to ensure that, as part of the organized program of housekeeping, procedures were developed and implemented for the cleaning and disinfection of devices including personal assistance services devices.

Observations of residents during the Stage 1 of the Resident Quality Inspection (RQI) found that eight of 40 (20 per cent) were observed to have unclean ambulation equipment. Eight residents had dust, dirt and spills on the seat, wheels and/or frame of their ambulation device. Ten days later, six of the eight residents were observed to have unclean ambulation equipment with dust and debris on the frame and/or wheels of their ambulation device.

Two Personal Support Workers (PSWs) said that the night shift staff cleaned the wheelchairs according to the cleaning list schedule in the lift and transfer binder and the Point of Care (POC). The PSW said that when working on night shifts in the past, they had tried to clean the wheelchairs as scheduled in POC, but at times they were unable to complete all assigned chairs. Another PSW said they were only able to clean six chairs due to time constraints. Both PSWs said that sometimes the list in the binder did not correspond to the residents assigned in POC if residents had moved rooms. The PSW said that they documented cleanings in the POC, but if it did not correspond to the list in the binder then they were unable to document cleanings and said that if a resident was scheduled in the POC, but not on the list in the binder then they would document as “Not Applicable”.

Documentation in the POC tasks showed the following:
- Resident was scheduled to have their ambulation device cleaned once a week and this was documented as having been done two of four times (50 per cent).
- Resident was scheduled to have their ambulation device cleaned once a week and this was documented as having been done one of four times (25 per cent).
- Resident was scheduled to have their ambulation device cleaned once a week and this was documented as having been done two of four times (50 per cent).
- Resident was scheduled to have their ambulation device cleaned once a week and this

was documented as having been done two of four times (50 per cent).
- Resident was scheduled to have their ambulation device cleaned once a week and this was documented as having been done three of four times (75 per cent).
- Resident was scheduled to have their ambulation device cleaned once a week and this was documented as having been done one of four times (25 per cent).
- Resident was scheduled to have their ambulation device cleaned once a week and this was documented as having been done one of four times (25 per cent).
- Resident was scheduled to have their ambulation device cleaned once a week and this was documented as having been done two of four times(50 per cent).

The Director of Nursing (DON) said that there was a process for cleaning wheelchairs and walkers in the home. The DON said that the night shift staff were responsible based on the POC tasks. They said that the cleaning of the residents' equipment was scheduled in POC and the expectation was that the staff would follow the POC tasks. The DON said they were not aware of the cleaning list in the lift and transfer binder. The DON said that wheelchairs and walkers were to be cleaned weekly and documented in POC when completed. Inspectors reviewed the POC for the resident with the DON and they acknowledged that it had been documented as having only been cleaned once in the past 30 days.The inspectors also reviewed the cleaning list schedule in the lift and transfer binder with the DON and they said this list was not the schedule to be used by staff and the expectation was that the chairs were to be cleaned weekly and documented in POC.

Inspectors observed the ambulation devices for five residents with the DON and they acknowledged the ambulation devices were not clean.

The home's policy titled "Commodes, Wheelchairs, Lifts – Cleaning Guidelines" included the following:
- "All equipment will be cleaned and well maintained."
- "All wheelchairs, walkers, gerichairs, commodes, lifts and shower chairs are to be cleaned daily by the PSW's."
- This policy did not include reference to how the cleaning was scheduled or documented.

The DON said that the home's policy titled "Commodes, Wheelchairs, Lifts - Cleaning Guidelines" was the current policy for the home and acknowledged that this process was not being followed in the home and they were working on revising the procedures for scheduling and documenting the cleaning of chairs.

Based on these observations, interviews and record reviews it was found that procedures were not implemented for the cleaning and disinfection of devices including personal assistance services devices. The process did not include a schedule for the cleaning of commodes, wheelchairs and lifts within the policy and procedure for documenting when a personal assistance services device had been cleaned. [s. 87. (2) (b)]

Additional Required Actions:

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

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A Medical Pharmacies Medication Incident Report was completed for a resident. The Registered Practical Nurse (RPN) administered a medication to the resident that was prescribed for another resident. The Director of Nursing (DON) and the Resident Care Coordinator (RCC) verified the resident received another resident's medication and the resident did not have a medication order for this drug. The RPN verified that the incident occurred. The RPN stated the profile pictures in Point Click Care (PCC) for the two residents were very similar. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in

accordance with the directions for use specified by the prescriber.

During the Resident Quality Inspection (RQI) #2017_263524_0005, Compliance Order (CO) #001 was issued on April 28, 2017, and ordered the licensee to take action to achieve compliance by ensuring that time specific medications were administered to residents in accordance with the directions for use specified by the prescriber. This order was to be complied by May 31, 2017.

The licensee failed to ensure that a time specific medication was administered to a resident in accordance with the directions for use specified by the prescriber.

A) A Medical Pharmacies Medication Incident Report was completed for a resident. The Registered Nurse (RN) gave an extra dose of a controlled substance. The controlled substance was ordered as needed for a specific time frame and the controlled substance was given more frequently than prescribed. The RN misread the medication order set and the error was discovered at end of the shift during the narcotic count. The electronic Medication Administration Record (eMAR) Report documented that the controlled substance was administered more frequently than prescribed.The DON verified the resident did not receive the controlled substance in accordance with the directions for use specified by the prescriber.

B) A Medical Pharmacies Medication Incident Report was completed for a resident. The RPN who was to administer a dose of a controlled substance at a scheduled time noted the incorrect dosage packaged by pharmacy. The narcotic card had the wrong dose packaged. The resident received a smaller dose then what was ordered.The DON verified the resident did not receive the controlled substance as ordered by the prescriber. The RCC and Inspector reviewed the eMAR Report and the RCC verified that there was one dose of medication administered to the resident incorrectly on one occasion. The RPN who administered the medication verified the resident received a dose that was not prescribed.

C) A Medical Pharmacies Medication Incident Report was completed for resident. The RPN administered a the wrong type of medication to a resident. The Physician's Orders in PCC documented two different types of the same classification of medication. The DON verified the resident received the wrong type of medication and stated the RPN did not do the appropriate checks to ensure accuracy of the administration.

D) A Medical Pharmacies Medication Incident Report was completed for a resident. The

RPN applied a medication patch without removing the plastic backing. The DON verified the resident missed the dose of medication to be administered over three days and therefore the medication was not given as prescribed. The Physician's Orders in PCC documented that the medication was to be administered over three days.The RPN stated that the backing on the patch was not removed prior to administration to the resident.

Based on a review of the Medical Pharmacies Medication Incident Reports and the electronic Medication Administration Records, as well as interviews with the registered staff and Director of Care, four residents were administered medications that were not in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

The Critical Incident System (CIS) Report documented that staff received a call from a resident's family member reporting that the resident had an incident in their room. Staff immediately went to the resident's room and verified that an incident had occurred.

The Incident Note stated the resident was getting up from their chair to go to bed and a fall prevention strategy was not in place.The Registered Practical Nurse (RPN) stated the home had a falls prevention program and shared that one strategy to help minimize the resident's risk for falls was for staff to ensure call bells were within reach.

The care plan in Point Click Care (PCC) for the resident stated strategies in place for safety.

The Resident Care Coordinator acknowledged that at the time of the incident the strategy for fall prevention was not in place. [s. 6. (7)]

2. The licensee has failed to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) This inspection was initiated as a result of a Critical Incident System (CIS) Report submitted by the home related to an incident and injury.

The resident was admitted to the home with a recent injury related to an incident. A review of the plan of care on Point Click Care at the time of the incident stated the resident required a higher level of care and staff assistance than required.

Review of the home's "Safety Plan – Resident" nursing policy stated that the "resident will be reassessed and the care plan reviewed and revised on a quarterly basis and when the resident's care needs change, the care set out in the plan is no longer necessary or the care set out in the plan has not been effective."

The Resident Care Coordinator (RCC) stated that at the time of the incident the resident was more physically capable than what was documented as part of the plan of care. The Resident Assessment Instrument Coordinator (RAI-C) said that the resident's physical functioning improved since the time of admission and stated that the care plan did not reflect how the resident had progressed and should have been updated to reflect that the care needs changed. (524)

B) A resident was observed with a personal assistance services devices (PASDs) in use. The last documented revision of the current care plan in Point Click Care (PCC) stated the resident used a particular PASD. The RCC and Inspector were in the resident's room

and the RCC verified that the PASD was not in place for the resident. The RCC stated that the PASD had not been in place for an extended period of time and that the care plan should have been updated to reflect the current care needs in place for the resident.

The "Safety Plan - Consent Form (Appendix B)" documented the resident used a particular PASD. There was no documentation as part of the resident's clinical record when the use of the particular PASD was discontinued.

The progress notes in Point Click Care (PCC) related to the resident's use of a safety device documented that the resident was using the device several years ago. The Personal Support Worker (PSW) stated that the resident does no longer used a PASD and stated that the PASD was used before, but on a different mobility device.

The Care Plan - Resident policy stated the plan of care will be reviewed and revised at least quarterly, or more frequently as the resident's condition changes. "The plan of care will reflect the current health status of the resident and will give clear direction to those providing care."

The Resident Care Coordinator verified that there was no documentation of the resident being reassessed for the use of the PASD and the plan of care was not revised when the resident no longer used the PASD.

C) The Critical Incident System (CIS) Report documented that a resident had an incident and injury. The CIS documented the implementation of multiple fall prevention strategies in response to the incident.

The current care plan in PCC for the resident did not include interventions related to the use of particular falls prevention interventions stated in the CIS report.

The Care Plan - Resident policy stated the plan of care will be reviewed and revised at least quarterly, or more frequently as the resident's condition changes. The plan of care will reflect the current health status of the resident and that in the event the resident had returned from hospital, the plan of care would be reviewed and revised.

Review of the Caressant Care "Safety Plan -Resident" policy stated the Safety Plan interventions would be reviewed and the plan of care modified.

The Resident Care Coordinator (RCC) and Resident Assessment Instrument Coordinator

(RAI-C) verified that the interventions were not updated as part of the resident's plan of care.

The licensee has failed to ensure that the residents' plan of care was reviewed and revised at least every six months and at any other time when the residents' care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

A) Ontario Regulation 79/10 s. 114 (2) states, "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 current physician's orders for a resident documented a prescription for an medication and the order was changed. The RPN acknowledged that the label was incorrect and did not match the current medication order for the dose to be administered at a particular time and stated that there were yellow stickers in the medication cart that stated "DIRECTIONS CHANGED REFER TO MAR" and that one was not applied to the medication label for the resident.

The “Change of Direction” policy 4-9 stated the registered staff were to attach one “Directions Changed, Refer to MAR” sticker directly to the label over the directions if possible.

By telephone, the Clinical Consultant Pharmacist (CCP) stated that a change of direction sticker would be applied to the instructions to “see MAR” when there was a change. The CCP stated the default was always the eMAR for the current prescriber’s order and stated that the policy that supports this practice was called the “Change of Direction” Policy 4-9 where the registered staff were to attach one “Directions Changed, Refer to MAR” sticker directly to the label over the directions. This was to alert staff to refer to the eMAR only until the medication supply was completed.

The RPN verified that the policy related to a change in direction of a physician's order was not followed, that a sticker was not applied to the medication label for the resident and should have been when the order changed.

B) Ontario Regulation 79/10 s. 30 (1) states that, "Every licensee 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."

The required programs for Ontario Regulation s. 48 (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce

incidence of falls and the risk of injury."

The Critical Incident System (CIS) Report documented that a resident sustained an unwitnessed fall.

The Resident Care Coordinator (RCC) verified that the Glasgow Coma Scale documentation was incomplete. The RCC verified the neurological vital signs were not monitored and documented at the times specified in the assessment instructions.

The "Glasgow Coma Scale" paper assessment form stated neurological vital signs were to be monitored "Every half hour for the first two hours following a head injury. Every hour for the next four hours. Every four hours for the next eight hours. Finally once in eight hours."

The Glasgow Coma Scale was missing documentation on multiple occasions. The RCC verified that there was no other vital signs monitored or other neurological monitoring after a particular date and time.The RCC also verified that there was no other documentation in the progress notes related to monitoring of vital or other neurological signs after the unwitnessed fall.

The Head Injury Routine policy last reviewed July 2016 stated, “When a resident sustains any trauma to the head or has an unwitnessed fall, registered staff are to observe, evaluate and carry out examinations to determine changes in the resident’s status.” Registered staff were to assess the resident using the Glasgow Coma Scale and do a complete set of vitals for an unwitnessed fall. “A change in the level of responsiveness is the most sensitive indicator of improvement or deterioration.” “Using the Glasgow Coma Scale as a documentation tool and vital signs, assess the resident for 72 hours with the following frequency: Every half hour for the first two hours following the injury. Every hour for the next four hours. Every four hours for the next eight hours. Every shift for the remainder of the 72 hour monitoring.” The Head Injury Routine policy procedure also documented that the Resident Incident Report and Post Fall Investigation forms were to be completed.

The Director of Nursing (DON) verified the Head Injury Routine policy was reviewed annually as part of the Falls Prevention Program and stated that head injury routine was to be completed for any resident that sustained an unwitnessed fall or if the resident reported hitting their head. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written policy that dealt with when the doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

During the initial tour for the Resident Quality Inspection (RQI) the Inspector observed that there were two doors leading to outside secure areas that were unlocked. The door leading to the outside courtyard across from the Greenhouse Room had the electronic key pad with a green light showing and the door was not locked and there was a resident outside with no staff present. The temperature outside at the time was below zero.

Inspectors observed that the door leading to the outside courtyard across from the Greenhouse Room had the electronic key pad with a green light showing and the door was not locked and there were residents going in and out of the home with no staff present.

The Resident Care Coordinator (RCC) provided a policy called "Call Bell and Door Alarm" and said it was related to the locked doors leading to outside secure areas.

Review of the home's policy titled "Call Bell and Door Alarm" found it did not include procedures related to doors leading to secure outside areas and when the doors must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Inspectors observed that the door leading to the outside courtyard across from the Greenhouse Room had the electronic key pad with a green light showing and the door was not locked and five residents were outside and no staff present. A resident was observed to go through the door to the outside area without putting in a code.

A Personal Support Work (PSW) said that the door leading to the courtyard across from the Greenhouse Room was unlocked at certain times and the yard was fenced in. The PSW said that the residents come in and out all day and the hallway becomes very cold in the winter and said any resident was able to go outside unless mobility issues prevented them and that some residents who wandered in the home could wander outside unsupervised. The PSW said that no staff were specifically assigned for monitoring the courtyard but they would keep a visual on the residents when they walked by to see if anyone had fallen or if there were any concerns.

The Director of Nursing (DON) said that the door leading to the courtyard across from the Greenhouse Room was open for residents to go outside as they put the lock/code on bypass during the day. The DON said the door was locked between 2200 hours and 0500 hours and said that all residents had access to go out when they wanted. The DON said there were several residents who needed to be monitored and they would keep a visual on them to see if they noticed them outside. When asked if there were residents who needed to be supervised when outside, the DON said that some residents needed to be monitored and staff would know this by knowing the general condition of the resident. The DON said that no staff have been assigned to monitor the outside courtyard and said that the policy that was provided to the inspectors did not apply to doors to secure areas and said that there was no other policy regarding doors leading to secure outside areas of the home.

During the RQI it was identified through multiple observations that residents were entering and exiting the home through an unlocked door leading to a secure outside area. Based on interviews and record reviews it was identified that the licensee did not have a written policy that dealt with doors leading to secure outside areas in regards to when they were to be unlocked or locked to permit or restrict unsupervised access to those areas by residents. [s. 9. (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 written policy that dealt with when the doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the food service area of the home, the dining furnishings and food service equipment were kept clean.

During the lunch Dining Observation for the Resident Quality Inspection (RQI) the Inspector observed that the Cambro Cart had dirt build-up and food debris on the top, on the door and in the crevices of the cart.

The Inspector observed the Large Dining Room and the Main Kitchen and found the following:
- 18 out of 24 (75 per cent) tables in the Large Dining Room had dirt, debris and/or white splash marks on the table legs.
- The black floor mat in front of the small freezer in the Main Kitchen had dirt and food debris in the crevices.

- The small freezer had dirt and spills on the door on the left side of the unit.
- The Cambro cart had dirt and food debris on the top, on the door and the crevices of the cart.
- The gas stove had dirt and debris on the knobs and on the handle.
- The steam well had dirt build-up on the lower shelf.
- The walk-in freezer door had spills and dirt on the door.
- The walk-in fridge had dirt and debris on the floor, the wall behind the shelves on the right side had red spillage and there was dirt and debris on the shelves.
- The dry storage area had dirt and debris on the shelves, dirt on the floor and food debris on the top of the lid on one pail.
- The door leading to the Large Dining Room had dirt and spills on the side facing towards the kitchen.
- The floor in the kitchen had dirt debris at the corners and edges of the room.

The Cook said there were procedures in place for cleaning the kitchen including the equipment and storage areas and said that there were times when staff were not able to complete the cleaning tasks during their shifts due to other job demands.

The Food and Nutrition Manager (FNM) said there were policies and procedures in place within the home for cleaning the equipment and furnishings in the dining rooms and kitchen and said that there were times when the staff were unable to complete the cleaning as per the procedures and schedule due to other priorities with their time. The FNM said that the staff used a steam cleaner to clean the floor of the kitchen when doing a deep clean and this needed to be done at the time of the inspection, but due to the age and condition of the floor some of the built up residue would not come off. The FNM toured the Large Dining Room and the kitchen and said that the areas as listed above were not clean and said it was the expectation in the home that the dining room furnishings, food service equipment and the kitchen would be clean.

Based on these observations and interviews the licensee has failed to ensure that the that the food service area of the home, the dining furnishings and food service equipment were kept clean. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment were kept clean.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint regarding the cleanliness of the home. This complainant reported that the

housekeeping routines had been changed and that all rooms were going two weeks without being cleaned.

The MOHLTC received a complaint which included a concern with the cleanliness of the home and the complainant told the Inspector that there was dust on surfaces in the room and under their family member's bed.

During an initial Resident Quality Inspection (RQI) tour of the home the Inspector found that common resident areas in the home were not kept clean. The following was observed:
- The Main Lounge had dirt and debris on the games table as well as dirt and spill marks on the floor throughout the room and a build-up of dust and cobwebs along the perimeter and in the corners of the floor.
- The hallway in front of the door leading to the outside courtyard (across from the Greenhouse room) had dirt and sand on the floor.
- The Chapel had spills on the wall above the garbage, dirt and dust build-up under the computer table, piano and cupboards as well as along the perimeter and in the corners of the floor.
- The lounge at the end of the C Wing had dirt on the floor throughout the room as well as white debris on the television stand.
- The Greenhouse Room had dirt and dust under the cupboard as well as along the perimeter and in the corners of the floor.

Observations of resident bedrooms during the RQI by multiple inspectors found that 17/26 (65 per cent) of the rooms were found not to be kept clean. The following was observed for multiple resident rooms:
- used facial tissues and food debris on the floor beside the beds as well as dirt and spills on the door leading into the room,
- dirt and food debris under the bed and closet and on the baseboards in the bathroom,
- dirt on the floor behind the recliner and under the bed, on the baseboards, yellow and brown on the toilet under the commode seat, dirt build-up on call bell handle in the bathroom as well as dust build-up on the ceiling vent in the bathroom,
- dirt and debris on the floor mat, commode, toilet, baseboard, wall in the bathroom as well as dirt and dust under the closet,
- dust and dirt along perimeter of bathroom floor, dried brown splatter on bathroom wall and base of toilet, build-up of dust and yellow colouring with streaking down the front of the toilet,
- build-up of dirt and dust along the floor perimeter as well as in the bathroom, around the

toilet and on the baseboards. The call bell in bathroom had a build-up of dust along the cord,
- build-up of dirt and dust along the floor perimeter, the bathroom and baseboards and the toilet seat and base had dried urine,
- build-up of dirt and dust along the perimeter of the floor, baseboard heater, bathroom floor, toilet and along door frames,
- build-up of dirt and dust along the perimeter of the room and the bathroom and around the toilet and baseboards,
- dirt on the perimeter of the bedroom and bathroom as well as build-up of dust and cobwebs on the bathroom ceiling vent,
- build-up of dirt and dust along the floor perimeter as well as in the bathroom, around the toilet and on the baseboards,
- dust on bookcase shelves on wall and on heater,
- dirt on the perimeter of the bathroom floor,
- dirt and dust on the perimeter of the floor and dust on top of baseboard heater,
- cobwebs in the corner near the door to the room, and
- build-up dirt and dust behind room door and along perimeter of floor near bed, closet and in the bathroom.

The Family Council Meeting minutes were reviewed and it was found that they had expressed concerns regarding the cleanliness of the home. The meeting minutes included a concern that the raised toilets were not being cleaned. These minutes also included a concern regarding the cleaning of rooms, toilets not cleaned, floors having cobwebs in corners and sticky floors. These minutes also stated there were concerns about the dining room not being cleaned with stains on the walls and cobwebs by the doors. Other meeting minutes included a concern that the resident rooms and toilets were not being cleaned regularly. The Family Council documents also included a memo which stated that "deep cleaning schedules have been put into place and every room will be thoroughly cleaned. Housekeeping is to keep management informed of any issues that may arise and are required daily to submit an audit of work completed."

Observations of common areas and resident rooms by the Inspector found rooms were not kept clean. Multiple areas were found to have dirt and dust build-up along the perimeter of the rooms.

Two housekeepers they said that they each clean approximately 20 resident rooms per day. They said that they were not always able to get their work done each day. They said that some of the build-up of dirt on the edges of the floor and walls was difficult to get

during the day to day cleaning as they need to steam and scrape so they tried to do that on the deep cleaning shifts.

The Administrator said they were the lead for the Housekeeping Program in the home and said that on a daily basis the resident rooms were to be cleaned, the garbage bins changed as well as the floors swept and mopped. They said there was also a deep cleaning routine that staff worked through which included the room ledges, walls, curtains and behind the bed. They said that each room was to have a deep clean about every six months. The Administrator said that the common areas were assigned and cleaned on a weekly basis. They said that the common areas were swept and mopped according to the schedule and said that at the time of the inspection they needed to work on the deep clean of these rooms.

The Director of Nursing (DON) said they were responsible for scheduling the deep cleaning of the resident rooms for the housekeeping staff and said there were resident rooms that had not had a deep cleaning scheduled within the past six months.

The home's "Housekeeping Audit" for all resident rooms showed that 19/51 (37 per cent) were documented as having had a "Thorough Cleaning" completed in the past six months.

Inspectors toured the Main Lounge, the small lounge, the Chapel and seven resident rooms with the Administrator. During this tour the Administrator said they would expect the common areas to be cleaner and that although they have been working to make improvements to the cleanliness of the home and revising the housekeeping routines they had to prioritize which areas would be the focus for cleaning in the home. The Administrator acknowledged that the floors in the common lounges were not clean and knew the Chapel had not been cleaned and said that some of the areas in the resident rooms that were identified should have been cleaner.

Based on these observations, interviews and record review it was found that common areas and resident rooms of the home were not kept clean. [s. 15. (2) (a)]

3. The licensee has failed to ensure that the food service area of the home and food service equipment were kept in a good state of repair.

During the lunch Dining Observation for the Resident Quality Inspection (RQI) the Inspector observed that the Cambro Cart had dirt build-up and food debris on the top, the

door and in the crevices of the cart.

The Inspector observed the Main Kitchen and found the following:
- 18 out of 24 (75 per cent) tables in the Large Dining Room had dirt, debris and/or white splash marks on the table legs.
- The black floor mat in front of the small freezer in the Main Kitchen had dirt and food debris in the crevices.
- The Cambro cart had dirt residue on the door.
- The gas stove had the paint worn off the oven doors and the stove top.
- The wall to the right of the walk-in freezer was peeling off.
- The walk-in fridge had dirt and debris on the floor, the wall behind the shelves on the right side had red spillage and there was dirt and debris on the shelves.
- The floor in the kitchen had dirt debris at the corners and edges of the room.

The Food and Nutrition Manager (FNM) said there were policies and procedures in place within the home for cleaning the equipment and furnishings in the dining rooms and kitchen. The FNM said that the staff used a steam cleaner to clean the floor of the kitchen when doing a deep clean and this needed to be done at the time of the inspection, but due to the age and condition of the floor some of the built up residue would not come off. The FNM toured the kitchen and said that the areas as listed above were not in good repair and said it was the expectation in the home that the kitchen and equipment would be in good repair.

Based on these observations and interviews the licensee has failed to ensure that the that the food service area of the home and food service equipment were kept in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #7: 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 used safe transferring and positioning devices or techniques when assisting residents.

A resident stated that two Personal Support Workers (PSWs) transferred the resident and caused an injury. The Inspector reported the incident to the Director of Nursing (DON) and the DON verified that the resident was able to recall events with clarity.

Review of the home's investigation notes documented that there were several unsuccessful attempts to transfer the resident and the resident sustained an injury.

The DON verified that the two PSWs did not use safe transferring and positioning devices or techniques when assisting the resident with a transfer. [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 that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure when the resident had fallen, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The Critical Incident System (CIS) Report documented that resident had a fall and injury.

The Resident Assessment Instrument-Coordinator (RAI-C) and Registered Practical (RPN) stated that the assessment used post falls was called the "Safety Plan - Post Fall Investigation" and stated that after every fall, the paper "Safety Plan - Post Fall Investigation" needed to be completed. The RCC stated a "Safety Plan - Post Fall Investigation" was not completed after the three falls for the resident.

The Caressant Care: Care, Assess, React, Evaluate Policy documented that a Post Fall Investigation Form was to be completed post fall. The Caressant Care "Safety Plan - Resident" policy documented that an internal incident report, Post Fall Investigation and progress note was to be completed post fall.

The Director of Nursing (DON) stated registered nursing staff were to complete the "Safety Plan - Post Fall Investigation" after every resident fall. [s. 49. (2)]

2. The Critical Incident System (CIS) Report documented that a resident had a fall and injury.

The RCC stated that after every fall, a "Safety Plan - Post Fall Investigation" needed to be completed on paper. The RCC verified that the Post Fall Investigation for the resident was not completed.

The DON stated registered nursing staff were to complete the "Safety Plan - Post Fall Investigation" after every resident fall and did not. [s. 49. (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 when the resident has fallen, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that advice related to concerns or recommendations from Family Council was responded to in writing within 10 days.

A Family Council member and the Activity Coordinator who was the assistant to Family Council, indicated that advice related to concerns or recommendations were not always responded to in writing within 10 days.

Review of the Family Council meeting minutes indicated concerns were brought forward by family members related to:
- Fingernails of residents not always cut during bathing;
- Raised toilets were not always being cleaned;
- Fruit not always available on the nourishment carts;
- Request for more bananas to be available;
- Concerns about large portion sizes and so many fluids for residents.

There was no evidence that these concerns were followed up in writing within 10 days.

Review of the Family Council meeting minutes from a different month stated that "there

were a few concerns from the last meeting but we did not get any response." In addition, other concerns were raised by family members related to:
- Cleaning of resident rooms; toilets were not cleaned, floors had cobwebs in corners and floors were sticky; garbage was not being emptied in the rooms;
- Dining Room not being cleaned;
- Parking in the front parking lot;
- Laundry problems with clothes not coming back quickly;
- Aprons not always available for residents during meals;
- Scheduling of the Occupational Therapist.
A response letter was received from the Administrator and Nutritional Manager but not until weeks later and did not specifically address cleaning of resident rooms.

Review of the Family Council meeting minutes from a particular month indicated concerns related to:
- Bad smell on B wing and the dirty utility rooms;
- Resident rooms and toilets not being cleaned regularly;
- Garbage not being emptied often enough.
A response letter was received from the Director of Nursing but not until weeks later to address the specific concerns.

Review of the recent Family Council meeting minutes indicated concerns related to:
-asking if cream could be available for residents' coffee during meals;
-asking for new blinds in the dining room and activity lounge.
There was no evidence that these concerns were followed up in writing within 10 days.

The Administrator acknowledged that responses to Family Council concerns or recommendations were not always followed up in writing within 10 days and the expectation was that concerns and recommendations were responded to within the appropriate time frame. [s. 60. (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 advice related to concerns or recommendations from Family Council is responded to in writing within 10 days, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policies and procedures the home had in place for the cleaning of equipment related to the food production system and dining and snack service; the cleaning schedule for all the equipment; and the cleaning schedule for the food production, servery and dishwashing areas were complied with by the staff of the home.

During the lunch dining observation for the Resident Quality Inspection (RQI) the Inspector observed that the Cambro Cart had dirt build-up and food debris on the top, the door and in the crevices of the cart.

The Cook said there were procedures in place for cleaning the kitchen including the equipment and storage areas which included a posted schedule which staff were to sign off when the job had been completed. The Cook said that there were times when staff

were not able to complete the cleaning tasks during their shifts due to other job demands.

The Inspector toured the Large Dining Room and the Main Kitchen with the Food and Nutrition Manager (FNM) and it was identified that there were areas and equipment that were not clean at the time of the inspection. The FNM said there was a policy in place in the home for cleaning the food service and dining areas and said they used a three week cleaning schedule rotation and these were posted in the kitchen. The FNM said that each shift was expected to complete specific cleaning duties and then sign off that they had completed the task and said that at times the staff were not able to complete the assigned tasks due to other job demands.

The FNM provided the "Weekly Cleaning" schedule and "Daily Cleaning Schedule" forms. These sheets said, "cleaning tasks are to be completed daily as per policy/procedures" and "tasks are to be signed off after completion. A review of these sheets by the Inspector found the following cleaning tasks were not signed off as having been completed during this time period:
- "Cambro Cart" four of 18 times (22 per cent) that the task was on the schedule.
- "Back Storage Room" three of 15 (20 per cent) that the task was on the schedule.
- "Walk in Fridge" two out of 16 (13 per cent) that the task was on the schedule.
- "Stove Top" two of eight (25 per cent) that the task was on the schedule.
- "Table Legs & Chairs" in the Large Dining Room 14 of 22 (64 per cent) that the task was on the schedule.
- During one week, 25 of 37 (68 per cent) of the weekly cleaning tasks on the schedule.
- During the time period of 14 days, 52 of 331 (16 per cent) of the daily cleaning tasks on the schedule.

The home's policy titled "Food Production – Safety & Sanitation Cleaning Policy Food Services" included the following procedures:
- "Cleaning Schedules must be posted monthly and signed off on by the staff assigned to complete the task. The Food Nutrition Manager will follow up with any incomplete tasks as part of their daily rounds."
- "The Dietary Staff are responsible to complete the Cleaning Procedures as assigned on the Cleaning Schedule and initial once complete."

The Inspector reviewed the daily and weekly cleaning schedules with the FNM and they said that all cleaning tasks were not completed as per the schedule and the policy. The FNM said it was the expectation in the home that the staff completed and signed-off on

the cleaning tasks as outlined on the daily and weekly cleaning schedules as part of the home's written cleaning policy. [s. 72. (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 that the policies and procedures the home has in place for the cleaning of equipment related to the food production system and dining and snack service; the cleaning schedule for all the equipment; and the cleaning schedule for the food production, servery and dishwashing areas are complied with by the staff of the home, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the documented record was reviewed and analyzed for trends, at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record was kept of each review and of the improvements made in response.

A) A Critical Incident System Report showed that a resident had complained to the Administrator related to poor treatment of the resident.
B) A Critical Incident System Report indicated a family member called the Administrator to express concerns regarding a skin issue.
C) A Critical Incident System Report indicated a resident had complained that a Personal Support Worker had improperly provided care.
D) A Critical Incident System Report showed that a had complained to the Administrator that a Personal Support Worker injured them and a Registered Practical Nurse failed to administer their medications.
E) A Critical Incident System Report indicated a resident complained to the Administrator that they were verbally abused by a Registered Nurse.

The home's "Responses to Complaints" policy indicated that "a copy of all complaint and responses should be kept in a Complaints binder and logged on the Complaints Log." Review of the home's critical incident monthly log showed that the above alleged abuse/neglect incidents were logged as critical incidents of staff to resident abuse/neglect.

The Administrator stated that the home logged reports of alleged abuse in the critical incident system log, and not on the complaints log/tracker and that the quarterly "Analysis of complaints" reports had not included the complaint critical incidents. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the documented record is reviewed and analyzed for trends, at least quarterly; the results of the review and analysis are taken into account in determining what improvements are required in the home; and a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and a written record was kept of everything.

The Resident Care Coordinator (RCC) verified that quarterly review was undertaken of all medication incidents and adverse drug reactions at the Professional Advisory Committee (PAC). The RCC shared that the "Clinical Consultant Pharmacist Quarterly Report" and the Medical Pharmacies medication safety meeting minutes were created by

the Clinical Consultant Pharmacist (CPC) and discussed at PAC.

1. The Director of Nursing (DON) and the Inspector reviewed the Medical Pharmacies medication safety meeting for the time period between July and October 2017.

A) The written record of the meeting minutes identified an medication incident related to the wrong resident and documented, “wrong resident: look familiar: what 2 qualifiers do we have: the eMAR photo, which didn't help in this instance, can we take a new photo and then wheelchair ID or consider name bracelets for all residents who agree to wear one” related the incident. The DON verified that the changes and improvements identified in the review were not implemented. The DON stated that these were suggestions and just the alert on the individual resident medication bin in the cart and on Point Click Care was implemented immediately as corrective action after the incident. The DON verified that there was no written record that any of the suggestions were implemented.

B) The written record of the meeting minutes identified one medication incident related to an extra dose of medication administered, however there was no other documentation. The incident was related to the palliative orders and the extra dose of a controlled substance administered to a resident. The DON verified that the quarterly review did not include the medication incident related to the extra dose of controlled substance as part of the palliative orders and there were no changes or improvements identified as part of the written record.

2. The Resident Care Coordinator (RCC) verified that the medication incident related to the controlled substance palliative orders were not reviewed as part of the quarterly review for medication incidents for a particular quarter.

The DON and the Inspector reviewed the Medical Pharmacies medication safety meeting related to the most recent quarter.

A) The written record of the meeting minutes identified a medication incident related to processing and documented, “check for allergies with new orders, allergies are required on all documents where meds are ordered/given; notify pharmacy if allergies are not accurate when the new order sheets are sent". The DON verified that not all registered staff were made aware of this change or improvement, only those staff who attended this meeting would have known. The DON acknowledged that there was no written record that this change or improvement was implemented.

B) The written record of the meeting minutes identified a medication incident related to dispensing and documented, “1/2 and 1/4 tabs are difficult to work with, staff were instructed to watch closely for size/shape as the automated system cannot scan for narcotic errors”. The DON verified that there was no written record that this change or improvement was implemented and only those registered staff who attended this meeting would have known.

The Medical Pharmacies "Medication Incident Reporting" Policy 9-1 last revised January 2018 stated the Clinical Consultant Pharmacist (CPC) would report the consolidated reviews of the incidents with the Medication Safety Team and all medication incidents would be reviewed by the home’s "interdisciplinary team" and changes and improvements identified in the review would be implemented and a written record kept on file at the home.

The quarterly review was not undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review and for some of the changes and improvements identified in the review were not implemented and there was no written record kept of everything. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and a written record is kept of everything, to be implemented voluntarily.

WN #13: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored and the symptoms were recorded and that immediate action was taken as required.

A resident had an infection according to the most recent Significant Change in Status Minimum Data Set (MDS) Assessment. The resident was also documented as having the same infection according to the previous Quarterly MDS Assessment.

Review of the clinical record in Point Click Care (PCC) for the resident documented the following:
- “Vital Signs or Systems Assessment Note” were not completed every shift when the infection was present.
- “Physician visit/contact Note” documented on several occasions the presence of symptoms related to an infection.
-.“Weights & Vitals” tab in PCC was missing documented temperature readings when the resident had an active infection.

The Resident Care Coordinator (RCC) shared that there was no policy on symptom monitoring for infections. The RCC shared that only during an outbreak would there be symptom monitoring as part of the line listing every shift; otherwise documentation would be under the vital signs tab in PCC or as a progress note. The Inspector and the RCC reviewed the vitals signs documented in PCC and the RCC acknowledged that the resident's symptoms were not monitored and the symptoms were not recorded every shift. The RCC shared they reviewed the vital signs in PCC and the "Vital Signs" progress notes and there was no symptom monitoring recorded every shift for three months when the resident was diagnosed with an infection. The RCC then suggested looking under the "Infection Note" in the progress notes and verified there were no infection progress notes documented at all for the resident.

The licensee has failed to ensure that when the resident had symptoms of infection and when those symptoms persisted for two months, that there was a record of the symptoms on every shift. [s. 229. (5)]

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 on every shift, symptoms indicating the presence of infection in residents are monitored and the symptoms ware recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The resident stated the staff only cleaned the resident's mouth maybe once or twice a week because the resident no longer had any natural teeth and does not use dentures. The Resident Care Coordinator was present with the Inspector in the resident's room when the resident stated staff provided mouth care on one day, but not the next day.

The "Personal Care Hygiene" task in Point of Care (POC) documented "Mouth Care" by Personal Support Workers (PSWs) for a 30 day look back period. For 19 of 30 days (63 per cent) mouth care was provided once a day and for 6 of 30 days (20 per cent) no mouth care was provided to the resident.

The Resident Care Coordinator reviewed the POC task documentation related to mouth care for the resident and verified that staff were not providing oral mouth care in the morning and evening and verified that the documentation had full consecutive days were mouth care documentation was missing; the resident did not receive mouth care and there were multiple days where the resident did not receive mouth care twice a day. [s. 34. (1) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included a description of the incident and the events leading up to the incident.

Review of the Critical Incident System (CIS) Report showed that a description of the alleged staff to resident abuse incident and the events leading up to the incident were not included in the report.

The Director of Nursing verified that the incident description and events leading up to the incident had not appeared in the critical incident report and acknowledged that this should have been included. [s. 104. (1) 1.]

2. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (i) names of all residents involved in the incident.

Review of the CIS Report showed that a resident allegedly abused by staff was not named in the report.

The Director of Nursing verified that the resident’s name had not appeared in the critical incident report and acknowledged that they should have been included. [s. 104. (1) 2.]

3. The licensee has failed to ensure that the report to the Director included the following actions taken in response to the incident: the outcome or current status of the individual or individuals who were involved in the incident.

The CIS Report documented "Investigation pending" to answer the question, "What is the outcome/current status of the individual(s) who was/were involved in this occurrence".

Another CIS Report documented "pending" to answer the question, "What is the outcome/current status of the individual(s) who was/were involved in this occurrence".

The Director of Nursing (DON) verified there was no material in writing related to the outcome or current status of the resident who was involved in the incident for two CIS Reports. [s. 104. (1) 3.]

WN #16: 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 :

The licensee has failed to ensure that drugs stored in a medication cart were secure and locked and failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

The medication cart was observed parked against the nursing station at the front entrance of the home for 10 minutes unlocked and unattended. There was no ward clerk at the nursing station desk or any registered nursing staff near by. Five residents were sitting within approximately four feet of the medication cart, two visitors and multiple staff walked by the cart during that time.

The Director of Nursing (DON) who was in the Administrator's office across from the unlocked cart was asked to verify the observation. The Inspector asked DON to open the drawers of the medication cart and the DON was able to access all medications for use in all the drawers, with exception to controlled substances. The DON verified the medication cart was unlocked and unattended and was parked in an area where staff, visitors and residents had access. The DON verified the controlled substances were not stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that controlled substances were stored within the locked medication cart and that controlled substances were stored in a separate locked area within the locked medication cart.

Issued on this 17th day of May, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563), AMIE GIBBS-WARD (630), INA REYNOLDS (524)
Inspection No. / No de l'inspection :	2018_606563_0005
Log No. / No de registre :	002000-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 4, 2018
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care on Bonnie Place 15 Bonnie Place, St Thomas, ON, N5R-5T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Justyna Zmuda

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee must be compliant with Ontario Regulation s. 87 (2)(a).

Specifically the licensee must:
a) Ensure that their written policy titled "Cleaning Guidelines – Thorough Cleaning" is fully implemented.
b) Ensure that there is a documented schedule for the "Thorough Cleaning" of the home, furnishings and equipment, including flooring and baseboards in resident rooms, bathrooms and common areas and that this schedule is fully implemented. The completion of the cleaning tasks outlined in the "Thorough Cleaning" schedule must be documented.
c) Ensure a monitoring process is developed and implemented, including the staff responsible for monitoring, to ensure that the home, furnishings and equipment are kept clean and sanitary. This monitoring process must be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that the procedures that had been developed as part of the organized program of housekeeping were implemented for cleaning floors, furnishings, and wall surfaces for resident bedroom and common areas.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint regarding the cleanliness of the home. This complainant reported that the housekeeping routines had been changed and that all rooms were going two weeks without being cleaned.

During an initial Resident Quality Inspection (RQI) tour of the home, Inspector found that common resident areas in the home were not kept clean. The following was observed:
- The Main Lounge had dirt and debris on the games table as well as dirt and spill marks on the floor throughout the room and a build-up dust and cobwebs along the perimeter and in the corners of the floor.
- The hallway in front of the door leading to the outside courtyard (across from the Greenhouse room) had dirt and sand on the floor.
- The Chapel had spills on the wall above the garbage, dirt and dust build-up under the computer table, piano and cupboards as well as along the perimeter and in the corners of the floor.
- The lounge at the end of the C Wing had dirt on the floor throughout the room as well as white debris on the television stand.

- The Greenhouse Room had dirt and dust under the cupboard as well as along the perimeter and in the corners of the floor.

Observations of resident bedrooms during the RQI by multiple inspectors found that 17/26 (65 per cent) of the rooms were not kept clean. Resident bedrooms were observed to have dust and debris along the perimeters of the room, under beds and closets as well as in bathrooms.

The Family Council Meeting minutes were reviewed and it was found that they had expressed concerns regarding the cleanliness of the home. The meeting minutes included a concern that the raised toilets were not being cleaned. These minutes also included a concern regarding the cleaning of rooms, toilets not cleaned, floors having cobwebs in corners and sticky floors. These minutes also stated there were concerns about the dining room not being cleaned with stains on the walls and cobwebs by the doors. Other meeting minutes included a concern that the resident rooms and toilets were not being cleaned regularly. The Family Council documents also included a memo which stated that "deep cleaning schedules have been put into place and every room will be thoroughly cleaned. Housekeeping is to keep management informed of any issues that may arise and are required daily to submit an audit of work completed."

During an interview with two housekeepers, they said that they each cleaned approximately 20 resident rooms per day and said they would sign off on the schedule when they had completed the jobs and these were kept by the Administrator. They said that they are not always able to get their work done each day. They said that some of the build-up of dirt on the perimeter of the floors and walls were difficult to get during the day to day cleaning as they need to steam and scrape and so they tried to do that on the deep cleaning shifts.

The Administrator said they were the lead for the Housekeeping Program in the home. The Administrator said that on a daily basis the resident rooms were to be cleaned, the garbages changed as well as the floors swept and mopped. They said there was also a deep cleaning routine that staff worked through which included the ledges, walls, curtains and behind the bed. They said that each room was to have a deep clean about every six months. The Administrator said they were unsure when the last deep clean for resident rooms had been done as these were being scheduled and monitored by the Director of Nursing (DON). The Administrator said that the common areas were assigned and cleaned on a weekly basis and at this time these were not completed as staff were assigned

to other tasks. They said that the common areas were swept and mopped and at the time of the inspection they needed to work on the deep clean of these rooms. The Administrator said they had made revisions to the routines of the housekeepers and were continuing to make changes and revisions at the time of the inspection based on priorities that had been identified. The Administrator said that they did a "walk through" of the home daily and that they used the "Housekeeping Routine" sheets to monitor and audit.

The "Housekeeping Routine" sheets showed the following documentation of the "daily rotation schedule" for the common areas :
- The Chapel was not documented as having been cleaned three of six scheduled times (50 per cent).
- The Main Lounge was not documented as having been cleaned three of five scheduled times (60 per cent).
- The small lounge in the C Wing was not documented as having been cleaned one of two scheduled times (50 per cent).

The Director of Nursing (DON) said they were responsible for scheduling the deep cleaning of the resident rooms for the housekeeping staff. The DON said there were resident rooms that had not had a deep cleaning scheduled within the past six months. The DON said they used the audit forms to track the "Thorough Cleaning" that was completed for the past six months in the home.

The home's "Housekeeping Audit" for all resident rooms showed that 32/51 (63 per cent) were documented as not having had a "Thorough Cleaning" completed in the past six months.

The home's "Common Area Housekeeping Audit" for the past six months, had eight of nine (89 per cent) areas not documented as having been completed.

The home's Housekeeping Department policy titled "Cleaning Guidelines – Thorough Cleaning" stated "all areas of the facility must be thoroughly cleaned as per schedule." This policy included the following procedure:
"Thorough cleaning: all daily cleaning items; stripping, re-waxing floors (if required) and buffering as per schedule; pull out furniture to clean behind; cleaning of inside windows; washing walls, ceilings (where possible); carbolozing of unit, including doors, closets, chest of drawers; removal of laundering of window curtains and privacy curtains (semi-annually or as per schedule); thorough dusting high and low; includes washroom area as well when

cleaning resident's room."

Inspectors toured the Main Lounge, the small lounge, the Chapel and resident rooms with the Administrator. During this tour the Administrator said they would expect the common areas to be cleaner and that although they have been working to make improvements to the cleanliness of the home and revising the housekeeping routines they had to prioritize which areas would be the focus for cleaning in the home.The Administrator acknowledged that the floors in the common lounges were not clean and knew the Chapel had not been cleaned. The Administrator said that some of the areas in the resident rooms that were identified should have been cleaner. The Administrator said that the routines did not include the floor mats and said they would expect staff to know and clean if they were in place, but that floor mats needed to be added to the routines. The Administrator acknowledged that the "Housekeeping Routine" sheets showed that there were cleaning jobs that had not been documented as having been completed, for example the common areas. They said that there were days when they would pull the staff to do other tasks and the common areas would not have been clean, for example the Chapel, and there was some of the weekly cleaning that had not been done. The Administrator said they were not sure when the last time the deep cleaning was done of the common areas.

The DON told Inspectors that they had been doing the scheduling for the deep cleaning for the resident rooms and was planning on scheduling staff for the common areas starting next week. They said they were using the "Common Area Housekeeping Audit" for the deep cleaning of common areas and acknowledged there was no date or schedule for the areas to be done. The DON said that the large dining room was documented as having been done and thought that the small dining room had also been cleaned. The DON said that no other common areas had been scheduled or completed.

Based on these observations, interviews and record review it was found that there were areas of the home that were not kept clean. It was identified that there was no schedule in place at the time of the inspection for the "thorough cleaning" of common areas and that the "thorough cleaning" of resident rooms had not been implemented as there were multiple rooms that had not had this completed in over six months. It was also identified that the procedures that had been developed as part of the organized program of housekeeping for cleaning resident rooms and common areas were not fully implemented.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 3 as it was widespread. The home had a level 4 history, despite Ministry of Health action with an order, non-compliance continues with the original area of non-compliance with this section of the LTCHA that included:
• Voluntary Plan of Correction (VPC) issued April 28, 2017 (2017_263524_0005)
• Voluntary Plan of Correction issued March 18, 2017 (2016_260521_0004)
(630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 08, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_263524_0005, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with Ontario Regulation s. 131 (2).

Specifically, the licensee shall ensure that:
a) A specific resident, and all other residents prescribed to receive Hydromorphone, are administered the Hydromorphone at the time prescribed by the physician.
b) A specific resident, and all other residents prescribed to receive Hydromorphone, are administered the correct dose of Hydromorphone prescribed by the physician.
c) A specific resident, and all other residents prescribed to receive insulin, are administered the correct insulin at the time prescribed by the physician.
d) A specific resident, and all other residents prescribed to receive a Fentanyl patch, are administered the Fentanyl according to the direction for use at the time prescribed by the physician.

Grounds / Motifs :

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

During the Resident Quality Inspection (RQI) #2017_263524_0005, Compliance Order (CO) #001 was issued on April 28, 2017, and ordered the licensee to take action to achieve compliance by ensuring that time specific medications were administered to residents in accordance with the directions for use specified by the prescriber. This order was to be complied by May 31, 2017.

The licensee failed to ensure that a time specific medication was administered to a resident in accordance with the directions for use specified by the prescriber.

A) A Medical Pharmacies Medication Incident Report was completed for a resident. The Registered Nurse (RN) gave an extra dose of a controlled substance. The controlled substance was ordered as needed for a specific time frame and the controlled substance was given more frequently than prescribed. The RN misread the medication order set and the error was discovered at end of the shift during the narcotic count. The electronic Medication Administration Record (eMAR) Report documented that the controlled substance was administered more frequently than prescribed.The DON verified the resident did not receive the controlled substance in accordance with the directions for use specified by the prescriber.

B) A Medical Pharmacies Medication Incident Report was completed for a resident. The RPN who was to administer a dose of a controlled substance at a scheduled time noted the incorrect dosage packaged by pharmacy. The narcotic card had the wrong dose packaged. The resident received a smaller dose then what was ordered.The DON verified the resident did not receive the controlled substance as ordered by the prescriber. The RCC and Inspector reviewed the eMAR Report and the RCC verified that there was one dose of medication administered to the resident incorrectly on one occasion. The RPN who administered the medication verified the resident received a dose that was not prescribed.

C) A Medical Pharmacies Medication Incident Report was completed for resident. The RPN administered a the wrong type of medication to a resident. The Physician's Orders in PCC documented two different types of the same classification of medication. The DON verified the resident received the wrong type of medication and stated the RPN did not do the appropriate checks to ensure accuracy of the administration.

D) A Medical Pharmacies Medication Incident Report was completed for a resident. The RPN applied a medication patch without removing the plastic backing. The DON verified the resident missed the dose of medication to be administered over three days and therefore the medication was not given as prescribed. The Physician's Orders in PCC documented that the medication was to be administered over three days.The RPN stated that the backing on the patch was not removed prior to administration to the resident.

Based on a review of the Medical Pharmacies Medication Incident Reports and the electronic Medication Administration Records, as well as interviews with the registered staff and Director of Care, four residents were administered medications that were not in accordance with the directions for use specified by the prescriber.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 2 as it related to four of eight residents reviewed. The home had a level 4 history, despite Ministry of Health action with an order, non-compliance continues with the original area of non-compliance with this section of the LTCHA that included:

• Compliance Order issued April 28, 2017 (2017_263524_0005)
• Voluntary Plan of Correction issued March 18, 2017 (2016_260521_0004)
(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 08, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Melanie Northey

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