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
Oct 5, 2017	2017_324535_0012	017319-17	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

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

VERON ASH (535), DEREGE GEDA (645), JENNIFER BROWN (647), SARAH KENNEDY (605)

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): July 31, August 1, 2,3,4,8,9,10,11,14,15,16,17,18,21,22,23,24,25,28,29, 30, 2017.

The following critical incidents were completed concurrently with the RQI: Log #003205-16 (related to CI #0922-000003-15 duty to protect), 028825-16 (related to CI # 0922-000032-16 prevention of abuse), 033808-16 (related to CI #0922-000042-16 prevention of abuse), 030125-15 (related to CI #0922-000028-15 duty to protect), 029403-16 (related to CI #0922-000035-16 responsive behavior), 033339-16 (related

to CI #0922-000041-16 responsive behavior), 034801-16 (related to CI #0922-000043-16 prevention of abuse), 005574-17 (related to CI #0922-000007-17 responsive behavior), 010695-17 (related to CI #0922-000015-17 prevention of abuse), 030555-16 (related to CI #0922-000038-16 plan of care), 032108-16 (related to CI 0922-000039-16 plan of care), 008803-16 (related to CI #0922-000009-16 and 0922-000008-16 duty to protect), 015136-16 (related to CI #0922-000019-16 duty to protect), 000451-17 (related to CI #0922-000001-17 falls prevention), 008303-17 (related to CI #0922-000012-17 plan of care).

The following complaints were completed concurrently with the RQI: Log #030572-15 (related to bill of rights/abuse), 033966-16 (related to bill of rights/restraint).

The following follow up inspection was completed concurrently with the RQI: Log #003481-17 (inspection #2016_252513_0011, Compliance Order #001 retraining of staff related to zero tolerance of abuse).

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Directors of Care, Registered Dietitian, Director of Dietary Services, Environmental Services Manager, Director of Resident Programs, Resident Relations Coordinator, Resident Assessment Instrument (RAI) Coordinator, Office Manager, registered staff RN/ RPN, personal support worker (PSW), housekeeping and laundry staff, President of Residents' Council and Representative of Family Council, Substitute Decision Makers (SDMs), and residents.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: meal service; medication administration; staff and resident interactions; provision of care, conducted reviews of health records, complaints and critical incident logs, staff training records, meeting minutes of Residents' and Family Council meetings, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Trust Accounts

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_252513_0011	535

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A CIR (Critical Incident Report) was reviewed related to resident #012 who was observed to have an injury. A review of the home's MDS assessment revealed that the resident was reasonable with consistent decision-making.

During an interview, the resident stated that the injury was caused by an instrument which was left unattended and unsupervised on the unit. On an identified date, the inspector observed that there were similar instruments left unattended and unsupervised in multiple locations in the home.

During an interview, registered staff RPN #100 stated that the instruments were usually stored in a secure location which was accessed only by registered staff; and a supply was provided to PSWs to support resident care. The registered staff confirmed that the instruments should have been used and disposed of in a special container.

During an interview, the ED #134 was informed of the inspector's observations above and he/she confirmed that the use of the instrument by a few residents in the home was a balance between resident's rights and risk and safety. However, the ED stated that the home completed a search of all home areas and have since removed all such instruments and they were now stored in a safe and secure location in the home. [s. 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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A CIR related to an incident involving resident #012 was reviewed and revealed that the resident had an injury.

Record review revealed that the resident had a diagnosis and had an assessment which confirmed that he/she was reasonable with consistent decision-making. A review of the

critical incident, investigation notes and progress notes revealed that resident #012 required assessments by the physician multiple times over a period of two weeks; and was being monitored closely for signs of distress.

Record review and staff interviews with PSW #135 and registered staff RPN # 138 confirmed that the resident was being closely monitored; however that information was not included in the resident plan of care to continue the monitoring procedure. Record review revealed that on an identified date, the resident was seen and assessed by the team. However, shortly thereafter, the resident was diagnosed with an injury. A review of the progress notes revealed that the resident was assessed by the registered staff and provided first aid then transferred to an acute care hospital for treatment. Record review revealed that on an identified date, the resident returned to the home with one to one staffing and monitoring interventions immediately initiated.

During an interview, the DOC #108 stated that the resident plan of care should have been updated by the registered staff with current information to ensure continued monitoring of the resident; therefore the plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident, the substitute decision maker (SDM), if any, and the designate of the resident had been provided the opportunity to participate fully in the development and implementation of the plan of care.

The Ministry of Health and Long Term Care ACTIONline had been contacted by a complainant who indicated that a resident had a change in medication without involving the resident or the SDM in the decision.

Review of the clinical chart indicated that the resident was admitted to the home briefly over an identified period. A further clinical chart review indicated that resident had been admitted with an order for a medication on specific days during the week. A review of the physician order forms indicated that there had been multiple medication dosage changed.

An interview with the complainant revealed that during the resident's admission to the home the family had requested that the medication dosage not be changed. Interviews with RN #115 and #142 indicated that any medication change was to be discussed with the SDM to ensure consent was received prior to administration. Further review of the above mentioned physician order forms indicated that the consent box had not been

completed for either dosage changes therefore the family was not contacted for consent related to the medication changes.

The Director of Care (DOC) acknowledged during an interview that resident #026 or the SDM was not provided an opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

3. A CIR was reviewed and revealed that resident #022 had a skin impairment of an identified area of the body related to an unknown cause.

Record review revealed that resident #022 was administered a daily medication which could cause bruising. A review of the home's MDS assessment indicated that the resident had responsive behaviors during personal care.

During separate interviews, registered staff RPN #146 confirmed that he/she did not notify the family that the resident sustained bruising and swelling of an identified area of his/her body. During an interview, registered staff #149 stated he/she could not recall if the family was notified; however there was no documentation to confirm that the family was notified after the physician had assessed the resident and ordered additional tests.

During an interview with the home's ADOC #109 and DOC #108 stated that the expectation was for registered staff to contact and update the substitute decision-maker if/when there were changes in the resident health status so that they could participate in the development and implementation of the plan of care. [s. 6. (5)]

4. 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.

A CIR was reviewed and revealed that resident #013 had an incident and was transferred to the acute care hospital.

A review of resident #013's written progress notes from an identified date revealed that the resident was found in his/her room after the incident. A review of resident #013's written care plan revealed instructions in place to support the resident and that he/she was not to be left unattended while providing care. An interview with PSW #124 revealed on an identified date, he/she was supporting the the resident during personal care; then he/she left the room to retrieve an item and upon return noted that the resident sustained an injury. PSW #124 stated he/she did not follow the written care plan as he/she left the

resident unattended.

An interview with the Director of Care (DOC) confirmed PSW #124 did not provide care to resident #013 as specified in the plan. [s. 6. (7)]

5. A CIR (Critical Incident Report) was reviewed and revealed that resident #022 had an injury to an identified area of the body.

Record review revealed that resident #022 was administered a medication which could cause an injury and was assessed to have responsive behaviors.

Record review of the progress notes revealed that the primary physician ordered a test; and the result confirmed the suspected injury. The progress notes also revealed that the physician spoke with the substitute decision-maker and ordered a treatment to be done and medication for the pain.

During separate interviews, PSW #136 and #145 both confirmed that they transferred the resident with the help of another staff; however both stated that they performed other personal care duties by themselves, although they were aware that the written care plan listed two staff extensive assistance to support the resident during personal care. During an interview, registered staff RN #122 stated that the resident only required two staff when resisting personal care but when the resident was in a good mood, usually one staff was sufficient to provide the care. During an interview, DOC #108 stated that the expectation was for direct care staff to provide care to the resident as specified in the plan of care; and that registered staff should reassess the resident and update the plan as needed to ensure accurate information was available. [s. 6. (7)]

6. During the Resident Quality Inspection (RQI) interview resident #003 stated that he/she would prefer a later time to wake up in the mornings. Record review revealed that the resident was alert and could make own decision; however he/she was concern about missing the breakfast. On multiple dates, the inspector observed the resident up and dressed before the identified time written in the care plan and the resident's desired wake up time.

During an interview, PSW #110 stated that he/she was aware of the time listed in the care plan, however he/she was earlier in order to be ready for breakfast. During an interview, registered staff RPN #111 stated that he/she was not aware of the resident's preference to remain in bed until a later time; but stated that the resident's preference to

wake up at a later time could be accommodated.

During an interview, the home's Director of Care (DOC) #108 stated that the expectation was for direct care staff to provide care to the resident as specified in the plan of care as related to sleep cycle; and that registered staff were expected to supervise and ensure that the residents' plan of care were being followed. [s. 6. (7)]

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

A CIR was review and revealed that on an identified date resident #023 sustained an injury of unknown cause to an identified area of the body.

Record review of the MDS assessment revealed that the resident had responsive behaviors and multiple diagnosis.

The inspector observed that the resident used a personal assistant supportive device (PASD) to move while in bed; however the resident's care plan listed a different PASD other than the device currently used by the resident. During an interview, registered staff #122 confirmed the above observation and stated that the resident's plan of care was not reviewed, revised and updated with the change to reflect the current status. During an interview, the home's DOC #108 stated that the expectation was for registered staff to review and update residents' plan of care when the resident's care needs change or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

8. Record review revealed that resident #004 was assessed for provision of personal care using a mechanical device. During the Resident Quality Inspection (RQI) interview resident #004 stated that he/she would prefer to wake up at a later time in the morning. On two identified dates, the inspector observed that the resident was awake, dressed and sitting in chair prior to the resident's preferred time. A review of the resident's care plan indicated the sleep cycle times for awaken in the morning which did not match the resident's current preference.

During an interview, PSW #106 stated that the resident usually asks what time it was when they wake him/her; however the resident never complained. During an interview, registered staff RPN # 107 stated that the resident had requested a later time for waking up in the morning; however the staff stated that sometimes they would leave the resident

in bed and get him/her up last. RPN #107 also confirmed that he/she did not revised the resident's plan of care to reflect the changes to support a later wake up time as requested.

During an interview, the home's Director of Care (DOC) #108 stated that the expectation was that registered staff receive the information and immediately review and revise the residents' plan of care to reflect changes. [s. 6. (10) (b)]

9. During the Resident Quality Inspection (RQI), the Minimum Data Set (MDS) assessment triggered for resident #010. Record review revealed that prior to admission the resident used an incontinent product; and at a later identified date, the resident required the addition of another incontinent product to support comfort and appropriate personal care.

During an interview, PSW #104 stated that the resident continued to use the same original incontinent product. A review of the resident's care plan included the use of the original incontinent product; and the resident profile worksheet revealed that the resident used a different incontinent product during the day, evening and night shifts. During an interview, the registered staff RPN/RAI Coordinator #105 stated that he/she requested a change of incontinence product for the resident based on the quarterly MDS assessment triggered recently. The RPN confirmed that he/she did not update the resident's care plan and the resident profile worksheet because he/she was being proactive and looking ahead to offer the resident a more suitable incontinence product; but stated that the profile and care plan should have been updated to reflect consistent information.

During an interview, the DOC #108 stated that the expectation was that registered staff reassessed the resident's continent status when the resident care needs change or when care was no longer applicable; and that the residents' incontinent product should matched the information included in the resident profile worksheet and the residents' plan of care. [s. 6. (10) (b)]

10. During the Resident Quality Inspection (RQI), the Minimum Data Set (MDS) assessment triggered for resident #011. Record review revealed that at admission the resident did not use an incontinent product; and the same for the period up to the next quarterly assessment period.

During an interview, PSW #101 confirmed that there were recent significant changes related to the resident's continence status since admission. According to the PSW, the

resident wore the same product during the day shift; however when he/she falls asleep the resident required a different incontinent product to maintain comfort and dryness. Therefore, during the night shift the resident consistently used an incontinent product; however during the evening and night he/she used a different incontinent product.

Record review of the resident profile worksheet revealed that resident #011 used the same incontinent product during the morning, evening and night shifts. Record review of the resident's care plan listed one incontinent product without specifying day, evening or night shift. During an interview, registered staff RPN #100 confirmed that the information recorded on the resident profile worksheet and in the resident's care plan does not reflect the true continent status of the resident; and he/she updated the information during the interview. RPN #100 also agreed that the information listed in both documents does not provide clear directions to direct care staff.

During an interview, the DOC #108 stated that the expectation was that registered staff reassessed the resident's continent status when the resident care needs change or when care was no longer applicable; and that the residents' incontinent product matched the information included in the resident profile worksheet and the residents' plan of care. [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 the plan of care set out clear directions to staff and others who provide direct care to the resident;
-to ensure the resident, the SDM, if any, and the designate of the resident/SDM are provided the opportunity to participate fully in the development and implementation of the plan of care;
-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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #019 was protected from abuse and neglect by anyone.

A CIR (Critical Incident Report) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, which revealed that resident #017 was engaged in a physical altercation with resident #019 which caused him/her to sustain an injury.

A record review of the home's investigation note revealed that resident #019 was engaged in a recreational activity with another co-resident when resident #017 walked in the room and without provocation, caused an injury to resident #019. Record review indicated that RPN #121 witnessed the incident and separated the two residents and called PSW #119 to monitor both residents. RPN #121 called charge nurse #120 into the room and reported the incident. Moments later, resident #017 again walked by resident #019 and engaged resident #019 in another altercation prior to leaving the room. A review of the home's investigation notes revealed that PSW #119, RPN #121 and charge nurse #120 were in the activity room during the second altercation initiated by resident #017.

An interview with resident #019 confirmed that resident #017 initiated the altercation between the two both times without provocation. Resident #019 confirmed that PSW #119, RPN #121 and charge nurse #120 were all present during the second altercation.

An interview with both PSW #119 and RPN #120 confirmed that they witnessed both incidents of altercation between the two resident and that resident #017 was the aggressor in both instances; and they agreed that the second incident could have been prevented. The charge nurse #120 indicated that resident #017's responsive behavior was challenging to manage; however the incident could have been prevented if they had

removed resident #019 from the area after the initial incident. Interview with Director of Care (DOC) also confirmed that the second altercation could have been prevented if resident #019 was removed from the area. [s. 19. (1)]

2. A CIR was reviewed and revealed that resident #021 was engaged in a physical altercation with resident #020 resulting in an injury.

A review of resident #021's chart revealed the resident had a medical diagnosis and was assessed to be cognitively impaired. A review of resident #020's chart revealed the resident had a medical diagnoses and was assessed to be cognitively impaired at the time of the incident; however he/she was currently deceased. In addition, a review of the chart revealed that the resident sustained an injury during the altercation.

An interview with RPN #130 revealed he/she witnessed the altercation between the two residents; and that resident #021 initiated the incident causing an injury to resident #020. A review of resident #020's written care plan revealed documentation which stated to always remind the resident not to go close to resident #021 to avoid altercations.
A review of resident #021's written care plan, from the time of the incident, revealed documentation which stated that the resident may become verbally abusive towards other residents without provocation; and that staff to ensure that resident #021 be placed in less congested area.

An interview with PSW #131 revealed resident #021 was currently much calmer; and during an interview RPN #130 revealed that resident #021 medications were adjusted, he/she no longer engaged other resident in altercations.

During an interview, the home's DOC confirmed that resident #020 sustained an injury during the incident, indicating abuse by resident #021. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse and neglect by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care included consent for restraining of a resident by a physical device, by the resident or if the resident was incapable, by the SDM.

A CIR was reviewed and revealed that resident #024 was restrained in the home by direct care staff using an unauthorized method of restraint.

According to the CIR, direct care staff used a prohibited form of restraint to prevent the resident from leaving the wheelchair. A review of the home's investigative notes revealed that this incident was also witnessed by other direct care staff who were not forthcoming; and who did not report the incident to management.

Record review of the MDS assessment revealed that the resident was moderately cognitively impaired with poor decision making and required cues and supervision for responsive behaviors.

During separate staff interviews, PSW #124, registered staff RN #133, ADOC #109, DOC #108 and ED #134, confirmed that the incident did occur and the resident was not harmed as a result of the incident. During an interview, the DOC confirmed that resident #024's SDM did not provide consent for the restraint to be used by direct care staff. [s. 31. (2) 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 the plan of care included consent for restraining of a resident by a physical device, by the resident or if the resident is incapable, by the SDM, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007, who was dependent on staff for repositioning was repositioned every two hours while in bed as per care plan direction.

Resident #007 was triggered during stage one of the Resident Quality Inspection (RQI). A record review of resident #007's care plan indicated that the resident needed to be turned and repositioned every two hours. Record review of the resident chart did not reveal any record of turning and repositioning documentation. During two separate observations on identified dates, the resident was observed lying in the same position as previously observed.

Interview with Primary PSW #114 revealed that he/she did not turn or reposition the resident as she was not aware that the resident needed to be turned and repositioned. PSW #114 is a full time staff and worked five shift this particular week and confirmed that she did not turn or reposition the resident. PSW #114 confirmed that the resident was a total care resident and the care plan directed staff PSWs to turn and reposition every two hours.

Interview with the charge nurse #115 confirmed that resident #007 was a total care resident and the care plan directs staff members to turn and reposition every two hour. Charge nurse #115 confirmed that PSW #114 should have turned and repositioned resident #007 every two hours while in bed as directed by the care plan. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the resident who is dependent on staff for repositioning is repositioned every two hours while in bed as per care plan direction, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure staff applied physical devices that have been ordered and approved by a physician or registered nurse in the extended class.

A CIR was reviewed and revealed that resident #024 was restrained in the home by direct care staff using an unauthorized method of restraint.

According to the CIR, direct care staff used an unauthorized form of restraint to keep the resident in the wheelchair. A review of the home's investigative notes revealed that the incident was also witnessed by other direct care staff who were not forthcoming; and who did not report the incident to management.

Record review of the MDS assessment revealed that the resident was assessed as moderately cognitively impaired with poor decision making and required cues and supervision, and displayed responsive behaviors. During separate staff interviews, PSW #124, registered staff RN #133, ADOC #109, DOC #108 and ED #134, confirmed that the incident did occur and that the resident was not harmed as a result of the incident. During an interview, the DOC confirmed that staff applied a physical device that was not ordered or approved by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

2. The licensee has failed to ensure that resident #024 was released from the physical device and repositioned at least once every two hours.

A CIR (Critical Incident Report) was reviewed and revealed that resident #024 was restrained in the home by direct care staff using an unauthorized method of restraint.

According to the CIR, direct care staff used an unauthorized restraint to prevent the resident from falling room the wheelchair. Record review of the MDS assessment revealed that the resident was moderately cognitively impaired with poor decision making, required cues and supervision, and displayed responsive behaviors.

During an interview, PSW #124 confirmed that the incident occurred, and that the resident was restrained for approximately two and one half hours until the end of his/her shift and into the next shift before the restraint was released in order to provide personal care. During separate staff interviews, registered staff RN #133, ADOC #109, DOC #108 and ED #134, confirmed that the incident did occur and that the resident was not harmed as a result of the incident. [s. 110. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure staff apply physical devices that have been ordered and approved by a physician or registered nurse in the extended class; -to ensure the resident is released from the physical device and repositioned at least once every two hours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that a prohibited form of restraint was not used in the home.

A CIR (Critical Incident Report) was reviewed and revealed that resident #024 was restrained in the home by direct care staff using a prohibited form of restraint. During interviews, PSW #124, registered staff RN #133, ADOC #109, DOC #108 and ED #134, confirmed that a restraint used was prohibited; and was used by staff because the resident was agitated and restless while sitting in the wheelchair. [s. 112.]

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 a sheet is not used as a restraint device in the home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the RQI and while the initial tour of the home was conducted, several residents' rooms were observed to be on contact precautions. There were eleven residents rooms observed to be identified as contact precaution; and each room was observed to have contact isolation precaution signs and Personal Protective Equipment (PPEs) gown and gloves placed on the doors. The precaution sign directed staff members to wear appropriate PPEs all the time when providing care to those identified residents in the rooms.

On an identified date, PSW #114 was observed entering an identified room without donning the appropriate PPEs (gown and gloves). PSW #114 was observed providing personal care for the resident in that room. On another identified date, PSW #101 was observed providing care to a resident in an identified room without donning the appropriate PPEs.

Interview with both staff members #101 and #114 confirmed that they did not wear the appropriate PPE at the time they were providing care to both residents on isolation precautions; and both reiterated that it was the expectation that they wear appropriate PPEs prior to providing care to residents who were on contact precautions.

Interview with the DOC confirmed that direct care staff members were expected to wear appropriate PPEs all the time prior to providing care for residents who were identified to be on isolation. He/she confirmed that the identified staff members did not participate in the implementation of the infection prevention and control program of the home. [s. 229. (4)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that alleged or suspected abuse incident involving resident #027 was immediately investigated.

A CIR was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to resident #027 and #028 engagement in physical altercation which may have resulted in an injury to an identified area of the body for resident #027. Upon assessment, resident #027 verbalized that he/she was not sure how he/she had sustained the injury; but stated that it could have been as a result of the physical altercation. The home submitted an incident report to MOHLTC as an alleged abuse on the same date; however, record review revealed that there was no investigation completed for the alleged or suspected abuse. The home was unable to provide any investigative documentations related to the incident.

An interview with both Assistant Director of Care (ADOC) and Director of Care (DOC) revealed that the home submitted an incident report for the alleged abuse to the MOHLTC; and both confirmed during the interview that this incident of alleged abuse was not investigated and reiterated that it was the expectation that the home conducted a full investigate with every alleged, suspected or witnessed abuse immediately. [s. 23. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure any actions taken with respect to a resident under a program, including assessment, reassessment, interventions and the resident's responses to interventions were documented.

A CIR (Critical Incident Report) was reviewed and revealed that resident #022 was noted to have impaired skin integrity located on two identified areas of his/her body of unknown

cause.

A review of the home's MDS assessment revealed that the resident was severely cognitively impaired and displayed responsive behaviors during personal care. During an interview, registered staff RPN #146 stated that upon assessing the resident, he/she completed the pain and skin assessments but did not document the same in the electronic system; the registered staff subsequently confirmed that a pain assessment and skin assessment should have been documented during the shift. During an interview, registered staff #149 stated that on an identified date, the physician assessed the resident as well, and ordered diagnostic tests. However, the registered staff confirmed that he/she did not document the skin and pain assessment with full awareness that both should have been documented within 24 hours of the incident.

During an interview with the home's ADOC #109, he/she confirmed that a pain and skin assessment was not documented by the registered on either instance. According to the ADOC, the expectation was that PSWs report skin issues to the registered staff, and that registered staff assess and document using the applicable electronic documentation applications within 24 hours.

During an interview, the home's DOC #108 stated that the expectation was for registered staff to document their assessment using the standardized applicable electronic assessments, and in this case a pain and skin assessments should have been completed. [s. 30. (2)]

2. A CIR (Critical Incident Report) was reviewed and revealed that resident #012 was observed with an injury to an identified area of the body.

Record review revealed that the resident was diagnosed with a disorder and was assessed to be independent with reasonable and consistent decision-making. Record review and staff interview revealed that on an identified date, the resident sustained an injury and was transferred to an acute care hospital for assessment and treatment. Record review revealed that on an identified date, the resident returned to the home with one to one staffing and a monitoring system interventions initiated.

Staff interviews and record review of the one to one Documentation Record form which was initiated revealed that on multiple identified dates, PSW #151 and PSW #152 monitored the resident on a continuous basis but documented hourly on the one to one Documentation Record form, although the instructions read that the form was to be

completed every 15 minutes.

During interviews, ADOC #109 and DOC #108 confirmed that they were unable to locate the resident's monitoring records from two identified periods; and the DOC confirmed that both PSWs should have monitored the resident continuously and documented in 15 minute intervals using the one to one Documentation Record form. [s. 30. (2)]

3. Record review revealed that on an identified date, resident #012 was discovered to have an injury to an identified area of the body. A review of the progress notes revealed that the resident was assessed by the registered staff and the physician, then transferred to an acute care hospital for assessment and treatment.

During an interview, registered staff RPN # 138 stated that he/she completed but did not document the skin assessment related to the incident. During an interview, DOC #108 stated that the expectation was that registered staff complete a skin assessment and document findings related to the incident. [s. 30. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 was bathed twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During the RQI interview, resident #003 stated that he/she would prefer to take a bath in the evenings before going to bed. Record review revealed that the resident was provided a shower twice weekly. During an interview, PSW #110 stated that the resident had informed him/her of their preference shortly after the resident's admission; and that he/she had informed the registered staff of the resident's preference. The PSW #110 could not recall the name of the registered staff; however, he/she confirmed that the changes were not made to the resident' plan of care to reflect the resident's preferences. During an interview, registered staff RPN #111 stated that he/she was not aware of the resident's preference to have a bath in the evening; and stated that this change could be accommodated.

During an interview, the home's Director of Care (DOC) #108 stated that the expectation was for direct care staff to try to accommodate residents' preferences related to personal care, including the method and time of day related to bathing. In addition, the DOC stated it was an expectation that the registered staff receive the information and update residents' plan of care. [s. 33. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the Resident Quality Inspection, the Minimum Data Set (MDS) assessment triggered for urinary incontinence related to resident #010. Record review revealed that prior to admission, the resident wore an incontinent product and continued to wear the same while in the home; however, over a period of months, the resident started experiencing occasional episodes of urinary incontinence which was captured in the quarterly assessment period.

During separate interviews, registered staff #100 and ADOC #109 both confirmed that a continent assessment was not complete for the resident although registered staff was aware of the resident's change in status. During an interview, the home's DOC stated that the expectation was that registered staff completed a continence assessment at admission, quarterly and with any significant changes in status; therefore, a continence assessment should have been completed using the clinically appropriate assessment tool. [s. 51. (2) (a)]

2. During the Resident Quality Inspection, the Minimum Data Set (MDS) assessment triggered for urinary incontinence related to resident #011. Record review revealed that the resident did not wear an incontinent product prior to admission because he/she was continent of bowel and bladder; and remain continent up to months later. Record review of the recent assessment revealed that the resident triggered for occasional incontinent and required the use of an incontinent product.

During an interview, the primary PSW #101 confirmed that there were recent significant changes related to the resident's continence status. According to PSW #101, the resident remained continent during the day shift except when he/she falls asleep at which time the resident would be incontinent of bladder; therefore during the night shift the resident consistently wore an incontinent product because he/she does not want to be woken during the night.

PSW #101 and RPN #100 both stated during separate interviews that the resident

currently wore a light incontinent product during the day shift; and another product during the night. Registered staff #100 further confirmed that a continent assessment was not completed to reflect the current significant changes related to the resident's decline in status during the night shift; and that the assessment should have been completed.

During an interview, the home's DOC stated that the expectation was that registered staff complete the continence assessment at admission, quarterly and with any significant change in status; therefore, a continence assessment should have been completed using the clinically appropriate assessment tool. [s. 51. (2) (a)]

Issued on this 10th day of October, 2017

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

Original report signed by the inspector.