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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d’Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Apr 21, 2016	2016_293554_0004	004756-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Hope Street Terrace
20 HOPE STREET SOUTH PORT HOPE ON L1A 2M8

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

KELLY BURNS (554), BAIYE OROCK (624), JULIET MANDERSON-GRAY (607), SAMI JAROUR (570)

Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): February 29, March 01-04, and March 07-11, 2016

The following intakes were reviewed and inspected upon concurrently with this inspection; intake #019486-15, 022370-15, 024189-15, 001998-16, 002203-16,005306-16, 005575-16, and 005824-16.

Summary of intakes inspected upon:
1) #019486-15 - related to a complaint, specific to care issues, lack of supplies, bathing equipment, air temperature, staffing, activities and cleanliness of the home;
2) #022370-15 - related to a critical incident, specific to staff to resident abuse;
3) #024189-15 - related to a complaint, specific to care issues, continence care, activation, and temperatures within the home;
4) #001998-16 - related to a critical incident, specific to a fall with injury, resulting in change in resident's condition;
5) #002203-16 - related to a critical incident, specific to staff to resident abuse;
6) #005306-16 - related to a critical incident, specific to resident to resident abuse;
7) #005575-16 - related to a critical incident, specific to staff to resident abuse;
8) #005824-16 - related to a critical incident, specific to medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care, Office Manager, Food Services Supervisor/Environmental Services Supervisor, Program Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping Aides, Dietary Aides, Activation Staff, Maintenance Worker, Residents, and Family.

During the course of this inspection, the inspector(s)toured the home, reviewed clinical health records, observed staff to resident interactions, reviewed resident council meeting minutes, reviewed activation records, daily surveillance records, line listing records, reviewed home investigational notes (specific to identified Critical Incident Reports),reviewed maintenance request log binder, reviewed home specific policies related to Resident Abuse-Staff to Resident, Resident Abuse by Persons Other Than Staff, Resident Falls, Responsive Behaviours, Responsive Behaviour Episode Debriefing, Skin and Wound Care Program-Pressure Ulcers, Falls Prevention Program, Pain Prevention Program, Infection Prevention and Control Program, including Case Definitions, Declaring an Outbreak, Outbreak Management, Droplet Precautions, Isolation, Hand Hygiene, Cleaning and Disinfecting Equipment, Hot Weather Policy, Care of A Resident During Cold Weather, Heat Assessments, Medication Management Policies, Bowel Continence, and Staffing-Agency Staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.

- **16 WN(s)**
- **11 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (1), by not ensuring that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, specifically as it relates to protecting residents from abuse by other residents.

Related to intake #005306-16, for Resident #049:

Resident #049 has a history that includes cognitive impairment.

Registered Nurse #100 and Personal Support Worker #130 indicated resident #049 lacks insight and has poor judgement; both indicated resident does not know the difference between right and wrong.

A progress note, for a specific date, provides details an incident of alleged sexual abuse involving resident #049 and resident #050.

Personal Support Worker #130, who works on the second resident home area, where resident #049 resides, indicated no awareness of alleged incident.

A review of the written plan of care, following alleged sexual abuse incident, fails to provide the planned care for the resident #049; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to resident #049, specifically as it relates to safe-guarding resident from sexual abuse by resident #050.

Registered Nurse #100 acknowledged that the written plan of care, for resident #049 fails to provide planned care, goals the care is intended to achieve and clear directions to staff specific to protecting resident #049 from abuse by co-residents. [s. 6. (1)]

2. The licensee failed to comply with LTCHA, 2007, s. 6 (1)(c), by not ensuring the plan of care set out clear directions to staff and others who provide direct care to the resident.

Related to intake #005306-16, for Resident #050:

Resident #050 has a history that includes cognitive impairment. Resident has a history of exhibiting socially inappropriate responsive behaviours, specifically non-consensual touching and making inappropriate comments of a sexual nature.

Progress notes were reviewed and provided the following details:

- During two identified dates - Resident #050 made inappropriate comments of a sexual nature towards a personal support worker and non-consensually touched another personal support worker.

- On a identified date - the progress note provides details an incident of alleged sexual abuse involving resident #049 and resident #050.

The plan of care, in place at the time of the above incidents provides the following direction to staff:

- Sexually inappropriate behaviours – interventions include, identify root cause of behaviour (trigger), develop strategies and alternate approaches to address the behaviour; monitor behaviour episodes and attempt to determine underlying cause; provide concise explanations of care and treatment prior to initiating; set boundaries of acceptable behaviours prior to care; provide flexibility in ADL (activities of daily living) routines to accommodate resident’s mood; two staff present when providing care if sexually inappropriate behaviours arise.

Registered Nurse #100 acknowledged that the interventions listed, in the plan of care for resident #050, are vague and do not provide clear directions to direct care staff, or others, when resident #050 is exhibiting sexually inappropriate responsive behaviours directed towards co-residents. [s. 6. (1) (c)]

3. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring that the care set out in the plan of care is provided to the resident as specified in the plan.

Related to intake #002203-16, for Resident #045:

Resident #045 has a history that includes cognitive impairment. According to Personal Support Workers and Registered Nursing Staff resident is dependent on staff for activities of daily living; resident can become agitated and or aggressive with care.

On an identified date, Personal Support Worker(PSW) #113 was attempting to provide care to resident #045. PSW #114 indicated being in the hallway and overheard PSW #113 struggling to provide care to the resident; both staff indicated resident #045 was being resistive to care. PSW #114 indicated entering the room of resident #045 to assist PSW #113 with care. PSW #114 went to the window side of the bed, lowered the bed rail and cradled resident with his/her body; PSW #113 indicated PSW #114 held resident's hands with his/her hands. PSW #113 indicated that resident continued to be resistive and at that time, PSW #114 climbed onto the bed and used his/her knee to restrain resident #045's extremity, in addition to using his/her hands. After care was provided, PSW #113 noticed resident #045 had bruising on his/her extremities. PSW #113 indicated pointing the bruising on resident's extremities to PSW #114, at which time, PSW #114 commented, I won't tell if you won't tell. The witnessed abuse incident by PSW #114 to resident #045 was reported to registered nursing staff four hours post incident.

The plan of care for resident #045 directs the following:
- Personal hygiene, dressing and incontinence care – total assistance of two staff, one staff to focus on distraction; allow flexibility in timing.
- High risk for skin breakdown – monitor skin during daily care and report signs of skin breakdown to registered nursing staff; use caution when providing care and or transferring resident; avoid bruising.
- Responsive Behaviours, can exhibit physical and or verbal aggression; easily agitated due to cognitive impairment – provide for flexibility in ADL routine, to accommodate resident's mood; leave and return at a later time if exhibiting aggression and or agitation.

The Director of Care and the Administrator indicated that Personal Support Workers #113 and #114 did not provide care as specified by the plan of care, for resident #045. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a monitoring process in place ensuring that there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident; and ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Under O. Reg. 79/10, s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs in the home.

Related to intake #005824-16:

A Critical Incident Report was received on a specific date for a medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

The CIR indicated that on an identified date it was suspected that Registered Practical Nurse (RPN) #135 gave another resident's medications to resident #052. An interview with Registered Nurse (RN) #132, revealed that just prior to the evening shift ending, on a specific date, resident #051 came by the nursing station and had indicated that he/she did not receive his/her medications for that evening. RN #132 indicated that he/she had asked RPN #135 if resident #051 had received his/her medications and RPN #135 had indicated that the medications had been destroyed, but when RN #132 checked the E-MAR records for this resident, the medications had been signed for as being given.

According to the Critical Incident Report, resident #052 was transferred to the hospital for assessment.

The home's policy, Medication Pass (#11-03), indicated that registered staff are not to sign for medications PRIOR to giving them to the resident.

An interview with the Director of Care and the Administrator indicated that during their internal investigation they determined that RPN #135 had been pre-pouring medications; both DOC and Administrator indicated that it is not the home's practice that a nurse signs for medications prior to administration. [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 there is a monitoring process in place ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (a), by not ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following observations were made during the dates of this inspection:

- Flooring in residents' rooms and washrooms were observed to have a build-up of blackish substance in corners, along wall edges and along the transition piece at the entry of the room, in identified resident rooms; throughout hallways on the third floor; under baseboard heaters; the communal washroom on the main floor; in the main floor, second floor and third floor dining rooms; as well, as within the second and third floor shower rooms, and bathing rooms;

- Washrooms in identified resident rooms were observed to have dark build up/staining around base of toilet and on the floor; in the communal washroom located on the main

floor; as well, as the second floor shower room and third floor bathing room.

- Ceiling vent - located in the second and third floor bathing rooms were observed dirty, with visible dark gray, stringy substance on vent blades;

- The bathing room, located on the third floor - the toilet seat was observed to be chipped and gouged, with visible yellowish-brown staining present within the chipped areas;

- The dining room located on the third floor - the laminate flooring was observed to be pulling from the wall, with the sub-flooring exposed and visible dust and debris;

-Windowsills - were observed to be have a black moist substance in sill and along window edges in the main floor dining room, as well as the second floor dining area.

Interview with housekeeping staff #140 and #141, both indicated to the inspector being aware of black substance accumulating along edges/corners of floors and walls in resident's rooms, bathrooms and communal areas. Both staff #140 and #141 indicated that they try to get those areas but sometimes there is not enough time to get to it.

Environmental Services Supervisor (ESS) indicated to the inspector that housekeeping staff should properly clean the build-up in residents’ rooms, washrooms and communal areas and it is not enough to just mop those areas.

Environmental Services Supervisor indicated it is an expectation that the home be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, s. 15 (2)(c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed during dates of this inspection:

- Flooring – the laminate or tiled flooring was observed cracked, chipped, torn or pulling away from the wall with the sub-flooring exposed in identified resident rooms; in the main, second (outside of the elevator, flooring duct taped) and third floor hallways (outside of room #307); in all dining rooms; in the bathing rooms on the second and third; in the communal washroom located on the main floor; as well as within the elevator. Water was observed on the floors within the two bathing rooms and appeared to be

seeping onto the sub-flooring and underneath the laminate flooring.

- Walls – chipped, gouged, and or damaged, with areas of exposed dry wall/plaster and or corner steel beading exposed, in identified resident rooms; within the second floor shower room, and the second and third floor bathing rooms; as well as all dining rooms.

- Wall Guards – observed loose and or missing in identified resident rooms; outside of room #323; as well as within the second and third floor bathing rooms.

- Door Guard – observed loose or chipped and having jagged edges, in identified resident rooms.

Door Frames – chipped, paint lifting and or missing with exposed steel in identified resident rooms; and in all bathing and shower rooms.

- Toilet – no caulking was noted around the base of the toilet and flooring in a specific resident's washroom and the communal washroom located on the main floor.

- Bedside Tables – finishing was observed peeling and or missing, in identified resident rooms.

- Foot boards on beds – observed gouged and or chipped in identified resident rooms.

- Ceiling Tiles – observed damaged in a specific resident room; in the second floor bathing room; as well as the third floor dining room. Ceiling Tiles observed to have brownish staining within two specific resident rooms.

- Portable Tables, used for tray service – 8 tables throughout the second and third floor home areas, were observed to be gouged along the table edges as well as the veneer finishing peeling.

- Hand-rails – observed to be loose within the hallways on the third floor, especially outside of identified resident rooms; the hand rail was observed missing with only exposed steel pegs on the wall adjacent to the stairwell, by the activity lounge.

- Ceramic Wall Tiles – were observed to be chipped, with jagged edges and or missing within the bathing rooms located on the second floor; and in the communal washroom on the main floor.

- Tub – located in the second floor bathing room, was observed to have rusty-orange staining as well as black staining embedded within the acrylic finish on the inside surface of the tub; gouged and or chipped areas were observed on the outside surface of the tub.

- Wires – exposed wires, from hanging call bell brackets, were observed protruding from damaged (square holes) walls in shower stalls within the bathing rooms located on the second and third floors.

- Window Screen – torn and tattered in the second floor bathing room.

- Counter-tops – the laminate finish was observed chipped, gouged and or missing in areas on the nursing stations (facing resident sitting areas) on the second and third floors; along sink/cupboard areas outside of the second and third floor dining rooms; as well as in the shower rooms on both resident home areas.

- Alcohol Based Hand Hygiene Station – observed to be rusted at the base of stand, which was located outside of the main dining area.

- Steel Piping – 3 pieces of steel (copper) observed extending approximately an inch from the wall within the shower stall, located in the second floor bathing room.

The maintenance person indicated to the inspector that he/she relies on staff to inform him/her of needed repairs or maintenance issues verbally or by using the maintenance log book, which is located at the nursing stations and within all departments. The repairs are completed right away unless parts are needed.

The maintenance log book was reviewed for a three month period; the maintenance log book failed to provide documentation that the maintenance repairs noted above by the inspector(s) were identified as needing repair.

Environmental Services Supervisor (ESS) indicated to the inspector that maintenance issues such as chipped walls is an ongoing project and that there is no scheduled time for repairs. A casual maintenance person is hired to fix cracks in walls and do painting jobs on as needed basis.

Not maintaining the home, furnishings and equipment in a safe condition and a good state of repair presents potential risks to the health, comfort, safety and well-being of

residents. [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 there is a monitoring process in place ensuring that the home, furnishings and equipment are kept clean and sanitary; and ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 16, by not ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The following was observed during dates of this inspection:

- A window in the third floor bathing room was observed to be open; the opening was measured to be 38.5 centimetres (cm). The bathing door was unlocked, although signage on the room indicated door was to be kept locked. This home is a multi-level home.

- The window in the second floor bathing room was observed to open 38.5cm; the window was closed at the time of this observation. The door to this room was found to be unlocked, although signage on door indicated that room is to be kept locked. The window screen on this window was observed to be tattered and torn.

There were residents within the vicinity of both the second and third floor bathing rooms.

The Director of Care was notified of the window opening greater than 15cm.

The Environmental Services Supervisor indicated having no knowledge that windows within the two bathing rooms were able to be opened greater than the 15cm. Environmental Services Supervisor indicated that all windows within the home were to be secured, not opening greater than legislative requirement; she further indicated, that she believed, that all windows had been secured following the 2015 Resident Quality Inspection.

It was further identified that the following windows, on the main floor within the home, could also be opened greater than the legislative requirement:
- Family Room – opens approximately 83cm;
- Activity Room – two windows open approximately 83cm;
- Gathering Room – two windows open approximately 83cm;
- Main Dining Room – 9 windows open approximately 33cm;

The windows within the family room, gathering room, activity room and the main dining room were all observed to have a stick within the window sill. This stick could be easily removed and the windows opened without difficulty. The main floor is a resident accessible area; residents have been seen within this area throughout the daytime during this inspection.

Personal Support Worker #109 indicated that there are residents within the home who are at known to be at risk for exit seeking and or elopement.

The Administrator indicated being aware that windows on the main floor, which is a resident home area, open greater than 15cm; Administrator indicated that the windows open beyond the requirement of 15cm to allow a breeze to flow into the rooms during group activities and meal times during the summer months.

Administrator indicated that she was not aware that the legislation referred to all windows within the home. [s. 16.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a monitoring process in place ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 20 (1), by not ensuring the written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The home’s policy, Resident Abuse – Staff to Resident
(#OPER-02-02-04) communicates that there is a zero tolerance of abuse toward a resident. The policy provides direction for identifying, reporting, investigating, and responding to suspected or witnessed abuse of a resident by persons other than staff.

The policy directs that all staff in the home will:
- If abuse is witnessed, separate the resident from the alleged perpetrator (if safe to do so); call for assistance if there is any risk to safety of any person.
- Stay at the scene to provide comfort and reassurance to the resident.
- Immediately report suspected or witnessed abuse to the Administrator, Director of Care or their designate (e.g. supervisor)
- In Ontario, anyone who suspects or witnesses abuse and or neglect that causes or may

cause harm to a resident is required by the LTCHA, 2007, to contact the Ministry of Health and Long Term Care (Director) Action Line.

Related to intake #002203-16, for Resident #045:

Registered Practical Nurse #104 reported a witnessed staff to resident abuse incident involving resident #045 by Personal Support Worker (PSW) #114. The reporting to the Director occurred on an identified date.

Details of this staff to resident alleged abuse incident are contained within the Critical Incident Report which was submitted to the Director.

Personal Support Worker #113, failed to comply with the home’s policy, Resident Abuse-Staff to Resident, as evidenced by the following:

- An incident of staff to resident abuse was witnessed by PSW #113, on an identified date and at a specific time; the witnessed incident was not reported to registered nursing staff until four hours following the alleged incident.
- There is no indication in the home’s investigation notes or statement written by PSW #113, that he/she (PSW #113) called for assistance during the incident.

The Administrator and Director of Care indicated that Personal Support Worker #113 did not immediately report the witnessed incident of staff to resident abuse, as PSW #113 did not want to confront PSW #114 as to his/her actions.

Administrator indicated it is an expectation that the home’s policy Resident Abuse-Staff to Resident is complied with. [s. 20. (1)]

2. Related to intake #022370-15, for Resident #044:

Written statement provided by Student-Personal Support Worker #119, as well as text messages (viewed) detail an incident in which Student-PSW #118 alleges witnessing PSW #117, who is a regular staff member, verbally and physically abusing resident #044, while providing care. Student-PSW #118, indicated, resident #044 was heard yelling, please stop, it hurts. Student-PSW #118 indicated that the incident of staff to resident verbal and physical abuse occurred on a identified date and at a specific date.

According to text messages viewed and witness statement of Student-PSW #119,

another PSW #120, who is a regular staff, also had knowledge of the alleged staff to resident abuse incident, which occurred on the identified date. PSW #120 had knowledge of the incident on the date in which the incident took place.

Approximately twenty-four hours later, Student-PSW #119 approached a Registered Nurse (RN) and advised the RN of text messages that he/she had received the previous day, from another Student-PSW #118; the text messages were specific to staff to resident abuse in which Student-PSW #118 indicated having had witnessed during his/her shift on an identified date.

Administrator and Director of Care both indicated that the alleged incident of staff to resident abuse was not reported by neither Student-PSW #118 or PSW #120; the first report of the allegation of abuse was from Student-PSW #119 approximately twenty-four hours following the alleged incident.

Personal Support Worker #117, and Student-PSWs #118 and #119, failed to comply with the home's policy, Resident Abuse-Staff to Resident, as evidenced by the following:

- Personal Support Worker #118 indicated being present and witnessing the alleged verbal and physical abuse of resident #044 by PSW #117. Personal Support Worker #118 worked the day shifts during and proceeding the alleged incident. PSW #117 did not report what he/she allegedly witnessed to the shift supervisor, Director of Care and or Administrator. Administration of the home was advised of the incident by a third party, charge nurse via PSW #118.

- Personal Support Worker #118 did not separate resident #044 from PSW #117 during the alleged incident, nor did PSW #118 call for assistance during the alleged staff to resident abuse incident.

- Personal Support Worker #120 having knowledge of the alleged staff to resident abuse incident on a specific date, failed to report the incident to Director of Care and or Administrator.

- Personal Support Worker #119 having knowledge of the alleged abuse incident, on an identified date, failed to report such allegations until approximately twenty-four hours later.

Administrator and the Director of Care indicated that Personal Support Workers #118,

119 and 120 did not follow the home's policy, Resident Abuse-Staff to Resident. Administrator indicated staff are to immediately report an allegation, suspected or witnessed abuse to their supervisor immediately. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a monitoring process in place ensuring the written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 23, by not ensuring that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions, specifically the Alenti bathing chair.

Personal Support Workers, working within the home, use an Alenti (bath chair) for assisting residents into and out of the bathtubs and while bathing residents.

The ARJO HuntLeigh-Alenti instruction for use manual, dated October 2013, directs the following:

On page 15:
- use the safety belt at all times (this is written in bold print; this is also noted on page 17, 18, 20, 22, 25, 27, and 32)
- the safety belt helps resident to stay positioned properly on the seat
- WARNING (bold letters) - to avoid falls, make sure that the resident is positioned correctly and that the safety belt is being used, properly fastened and tightened

During dates of this inspection, the Alenti bathing chair was observed not to have an attached safety belt on the actual chair or within the bathing rooms located on the second and third floors of the home.

Personal Support Workers #109 and #110 indicated that they do not normally use the safety belt on the bathing chair (Alenti) when bathing residents. Both PSWs indicated that the safety belt may be used if a resident is known to slide from the chair. PSW #110 indicated that he/she rarely uses the safety belt, as residents find the safety belt to be cold when it gets wet.

Personal Support Worker #109 indicated new staff are trained to use the safety belt on the bath chair when bathing residents, as new staff do not know which residents could possibly slide off the bath chair while being bathed.

Director of Care indicated being unaware as to if the home had a manufacturer's instruction manual for the Alenti bath chair and further indicated having no recollection of reading an instruction for use manual for this device. Director of Care indicated being unaware that staff are to be using a safety belt, on the Alenti bathing chair, while using this device to bathe residents.

The Administrator was able to provide the Alenti instructions for use manual and indicated being aware that the safety belt was to be used during operation of this device; Administrator indicated being unaware that staff were not using the safety belt when using the Alenti bathing chair. [s. 23.]

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 monitoring process in place ensuring that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions, specifically the Alenti bathing chair, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 24 (2) 2, by not ensuring that the admission care plan, which identified resident #050, included, at minimum, any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

Related to intake #005306-16, for Resident #050:

Resident #050 was admitted to the long-term care home on an identified date. According the Community Care Access Centre (CCAC) application package, resident #050 had a history of exhibiting socially inappropriate responsive behaviours, specifically non-consensual touching of others.

The admission registered nursing staff indicated on the admission history and nursing assessment form being aware that resident #050 exhibited the above identified responsive behaviour.

Progress notes, post-admission day fourteen and day fifteen, provide details of resident #050 making inappropriate comments and non-consensually touching an identified individual.

The admission care plan failed to identify the risk that resident #050 may pose to others, including potential behavioural triggers, and safety measures to mitigate those risks, specifically as it relates to socially inappropriate responsive behaviours.

Registered Nurse #100 acknowledged that Resident #050’s care plan was not revised until a specific date, to reflect the above identified responsive behaviour; this date is approximately one month post admission. [s. 24. (2) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a monitoring process in place ensuring that the admission care plan, which identifies a resident, includes, at minimum, any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to comply with O. Reg. 79/10, s. 33 (1), by not ensuring 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.

A random review of six resident's clinical health records, including daily care flow sheets and the bathing schedules, identified that six of the six residents reviewed did not receive bathing, at minimum, of twice weekly, during a three month period.

Resident #001 and Resident #009 indicated not being bathed twice weekly on a consistent basis.

Personal Support Worker (PSW) #109 indicated that all residents are to receive twice weekly bathing. PSW #109 indicated that any refusals would be documented in the daily flow sheets and communicated to registered nursing staff, who would document refusals in the progress notes.

Personal Support Worker #109 and the Director of Care indicated that if the resident home area was short staffed, residents would receive a bed bath and such would be documented as such in the daily care flow record. Both indicated that there is a staffing back-up plan if the home is short staffed.

The Director of Care indicated she was aware that twice weekly bathing is not being documented in the daily flow sheets. Director of Care indicated if bathing was not documented, she would conclude bathing was not provided.

The Director of Care indicated that all residents, unless otherwise indicated in their plan of care, are to receive bathing at minimum of twice weekly. [s. 33. (1)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 57. (2), by not ensuring that a response is provided in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of Residents’ Council meeting minutes for a five month period indicated the following concerns with no written responses provided to the Residents’ Council:
- September 2015, Residents’ Council minutes identified concern related to shortage of staff on most days; Laundry concerns – clothing is not returning to residents in a timely fashion and clothes have more wrinkles than normal; Housekeeping concerns – Missing paper towels and toilet papers from many bathrooms and one bathroom is not cleaned every day.
- During a second meeting held in September 2015, Residents’ Council minutes identified concern related to shortage of staff on most days at least on one shift or another; Laundry concern where clothing is not returning to residents in a timely fashion.
- On January 2016, Residents’ Council minutes identified concerns related to odours in the west hall of the second floor; need for high dusting and more cleaning needed in some rooms than others.
- On February 2016, Residents’ Council minutes identified concerns related to shortage of staff – is it ever going to end; Laundry concern – missing clothing; Housekeeping concerns – odours in the halls especially around four specific resident rooms.

The assistant to the Residents’ Council, staff #144, confirmed that no written responses for the identified concerns were provided to the Residents’ Council. A request for information form was not completed and forwarded to the appropriate department for written responses. Typically if a form is completed a written response will be received. Staff # 144 indicated that copies of minutes of the Residents' Council meetings are posted in a week's time following the meeting and copies are sent to the Administrator and the Program Manager.

The Administrator indicated that written responses to the identified concerns should have been provided to the Residents’ Council within 10 days. [s. 57. (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 monitoring process in place ensuring that a response is provided in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 86 (2) (b), by not ensuring there are measures in place to prevent the transmission of infections.

Cross infection risks were observed during this inspection:

- Two cylinders of liquid oxygen, used to refill individual resident's portable oxygen units, were observed in the sluice/hopper room, located within the third floor shower room. A soiled commode pot was observed sitting on the edge of the hopper. The Administrator and the Director of Care both indicated this is where the home normally stores the two oxygen cylinders.
- Two cylinders of liquid oxygen, used to refill individual resident's portable oxygen units, were observed in the communal washroom, located within the second floor shower room. The two oxygen cylinders are used to refill individual resident portable oxygen units. The Administrator and the Director of Care both indicated this is where the home normally stores the two oxygen cylinders. Director of Care indicated that this washroom is used by staff and residents.
- A portable oxygen cylinder was observed sitting on the floor, beside the toilet, in the communal washroom, located within the second floor shower room.

Personal Support Worker #111, who works on the third floor, indicated the sluice/hopper room is used at times by nursing staff to clean soiled commode pots. Personal Support Worker #109 indicated the communal washroom within the second floor shower room is used by residents. Both PSW's #109 and #111 indicated the liquid oxygen refill cylinders are not cleaned prior to use by personal support workers.

The Administrator, who is the lead for the home’s Infection Prevention and Control Program indicated being aware that the oxygen cylinders (refill stations) are stored within communal washrooms (e.g. spa rooms) and or sluice/hopper rooms and such poses a risk of infections being transmitted. The Administrator indicated that the rationale for storing oxygen cylinders in the identified rooms, is due to the home lacking storage space. [s. 86. (2) (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 there is a monitoring process in place ensuring there are measures in place to prevent the transmission of infections, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by not ensuring that all staff participate in the implementation of the infection prevention and control program.

During dates of this inspection the following was observed:
- Room #211 – a bedpan was observed on the floor behind the toilet;
- Room #212 – a bedpan was observed on the floor behind the toilet; this item was observed to be soiled with a brown substance;
- Room #215 – a bed pan and a urine collection device (hat) were observed on the floor behind the toilet in a shared washroom; both items were unlabelled.
- Room #217 – a bedpan and a urine collection device (hat) were observed on the floor in a shared washroom; items were unlabelled.
- Room #218 – a bed pan was on the floor, under the sink, in a shared washroom; item was unlabelled.
- Room #309 – a urine collection device (hat) was observed on the back of the toilet, in a shared washroom; the item was observed to be unlabelled.
- Room #321- three washbasins were observed on the floor, in a shared washroom; items were all unlabelled.

Personal Support Worker #109 and Registered Nurse #106 indicated that all bedpans,

urinals and washbasins are to be labelled for individual resident use. Both staff indicated that the identified care items are to be cleaned following use and stored in each resident’s bedside table.

The Administrator, who is the lead for the home’s Infection Prevention and Control Program, indicated that all care items, which includes bedpans, urinals and washbasins are to be individually labelled to identify which resident has been assigned to use the care item, and further commented that all items are to be stored in the resident bedside table when not in use. [s. 229. (4)]

2. The home’s policy, Infection Surveillance and Control (#IC-03-01-01) directs that all care staff will record on the Daily 24-hour Symptom Surveillance form any symptoms that may determine an infection and or possible presence of a communicable disease outbreak. The policy directs that the Infection Control Practitioner or designate will review and analyze the Daily 24-hour Symptom Surveillance form each day, including weekends and determine if there is potential for an outbreak, based on case definitions as defined by the local public health and or provincial health authorities.

The home’s policy, Case Definitions (#IC-03-01-02) indicates that the home uses case definitions when reporting infections and for the purpose of surveillance and trend analysis unless otherwise directed by the local public health authority. The policy indicates the case definition is a set of uniform criteria used to define disease surveillance. Case definitions enable homes and public health authorities to count cases in a consistent manner. The policy directs that the Infection Control Practitioner or designate will adhere to the following case definitions when reporting an infection and for the purpose of surveillance and analysis unless otherwise directed by the local public health authority.

Respiratory Tract Infections:
Common Cold Syndromes / Pharyngitis – resident must exhibit at least two of the following signs and symptoms:
- Runny nose or sneezing
- Stuffy nose (congestion)
- Sore throat or hoarseness or difficulty swallowing
- Dry cough; and or swollen or tender glands in the neck

Pneumonia – all three of the following must be met:
a) Interpretation of a chest radiograph as demonstrating pneumonia, or the presence of a

new infiltrate
b) The resident must have a least one of the following:
- New or increased cough
- New or increased sputum
- Oxygen saturation < 94% on room air or a reduction in oxygen saturation of > 3% from baseline
- New or changed lung examination abnormalities
- Pleuritic chest pain
- Respiratory rate of greater or equal to 25 breaths per minute
c) At least one of the following:
- Fever
- Leukocytosis
- Acute change in mental status from baseline
- Acute functional decline

The home’s policy, Declaring an Outbreak (#IC-04-01-02), the indicates that staff will promptly identify a possible outbreak and notify the public health authority and other regulatory bodies as required. The home will review all signs and symptoms throughout the home on every shift. The Infection Control Practitioner and or designate and Director of Care must be aware of case definitions and declare a possible outbreak when symptoms meet the criteria of a possible outbreak. The home’s policy, Declaring an Outbreak, directs that registered nursing staff initiate a line listing to begin tracking residents with the date and time of onset of symptoms; include the symptoms that have been presented in the shifts report so that all staff can observe and report any other residents exhibiting the symptoms; suspect an outbreak and implement further control measures based on the symptoms and the possible mode of transmission if another resident becomes ill with similar symptoms within twenty-four hours. The policy further directs that the Infection Control Practitioner and or designate will inform the local health authority of the suspected outbreak immediately and follow their directive.

During the initial tour of the home, an inspector observed specific resident rooms to have signage indicating droplet/contact isolation-precautions.

The Administrator, who is the lead for the home's Infection Prevention and Control Program, acknowledged that there were residents within the home exhibiting specific illness related symptoms. The Administrator indicated that resident illness had not been reported to the public health unit as that would only necessary if there were two or greater residents displaying at least two specific illness related symptoms. Administrator

indicated that only one resident had been identified as having two specific symptoms as of today's date.

A review of the home's daily surveillance forms, line listing forms and individual resident progress notes, during a period of approximately one month identified twenty-one residents exhibiting illness related symptoms.

Administrator indicated that the registered nursing staff are responsible to communicate, to herself and the interdisciplinary team, any infection trends or illness within the home, as well as any worsening signs and symptoms of resident illness, and when there are two or greater residents exhibiting identified symptoms.

The Administrator indicated that registered nursing staff had not consistently communicated all signs and symptoms that the above identified ill resident's had been exhibiting.

The Administrator indicated that the Medical Officer of Health nor its designate had not been notified of a potential respiratory outbreak, within the home, prior to an identified date. [s. 229. (4)]

3. The home's policy, Droplet Precautions (#IC-03-01-09) indicates that residents ill with an infection that can be transmitted via droplets will be placed under droplet precautions until twenty-four hours after their symptoms have disappeared. The policy directs that if a resident needs to be outside of his/her room for any reason, a surgical mask must be worn; restrict movement outside of room as much as possible.

The policy further directs that any staff within two metres of the ill resident, are required to wear appropriate personal protective equipment.

During the dates of this inspection, residents who were in droplet/contact isolation due to exhibiting respiratory symptoms were observed sitting in the hallways, at portable tables, during specific meal times.

Personal Support Workers were observed delivering meal trays to the ill residents who were sitting in the hallways. Staff were not observed wearing PPEs during the delivery of the meal trays or meal time set up for the identified resident's.

Residents, who were not presenting respiratory symptoms, were observed walking past

ill residents in hallways.

Personal Support Workers #109 and #110, as well as Registered Practical Nurse #127 and Registered Nurse #100 indicated it is the home’s practice to allow ill residents to sit in the hall at portable tables during meal times, so that resident's can be supervised while eating.

Administrator, who is the lead for the home’s Infection Prevention and Control Program indicated being aware that ill resident’s on droplet-contact isolation/precautions are sitting in the hallways at meal times, and indicated that this was the only way that residents could be supervised during meals.

Administrator indicated that allowing ill residents to eat their meals in the hall is not the best practice and contradicts the home's policy, but that such has been the practice 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 there is a monitoring process in place ensuring that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the temperature in the home was maintained at a minimum of 22 degrees Celsius.

Related to intake #024189-15:

A review of the temperature log for the home between an approximate period of four month revealed that temperatures in the home were not consistently being maintained at a minimum of 22 degrees Celsius.

The DOC and the Administrator, both acknowledged that the temperatures, as recorded during the above period, were below 22 degrees. The DOC also stated that temperature measurements are done by nursing staff and these measurements are only done in the home between the months of May and September of each year.

The licensee has therefore failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. [s. 21.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 35 (2), by not ensuring the resident receives fingernail care, including the cutting of fingernails.

Resident #007 has a history that includes cognition impairment; resident is reliant on staff for activities of daily living; twice weekly bathing is scheduled for Wednesday and Saturday’s. Resident #007 is identified in the plan of care as being at risk for skin integrity issues.

Resident #007 was observed to have long nails with a dark brownish-black substance under his/her nails, during specific dates of this inspection, despite having a scheduled bath on three separate dates during this same period. The daily care flow record indicated resident #007’s nails were cleaned during the resident’s bath, but failed to provide evidence that resident’s nails were trimmed during this same time period.

The plan of care, in place at the time of this inspection indicated the following:
- Bathing: total assistance required with all aspects of bathing; two staff to assist with process of bathing.
- Check daily for needed finger nail trimming, to prevent skin breakdown.

Family, of resident #007, indicated that often resident's fingernails are not consistently kept clean and or trimmed.

Personal Support Worker #109 indicated that residents should receive finger nail care, which includes cleaning and trimming at least twice weekly with their scheduled bathing; PSW #109 further indicated resident’s nails should be cleaned and trimmed daily as needed.

Registered Nurse-Charge Nurse #100 and the Director of Care indicated that it is an expectation that fingernails are kept cleaned and trimmed. [s. 35. (2)]

WN #14: 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

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

Resident #047's clinical health record was reviewed for a period of approximately nine months; the record review indicated that the resident #047 was identified as having altered skin integrity issues and was to be receiving a medicated treatment order.

Weekly wound assessment were to be conducted for the resident, using a Weekly Wound Treatment Assessment form or a Wound Care record form.

Record review indicated the weekly skin assessments were not conducted for this resident for the specific time periods identified.

The home's policy, Pressure Ulcers (#03-07) indicated:

Following the completion of wound care treatments, Registered Nursing Staff are to document the completion of the wound care treatment. Weekly the wound is to be assessed to evaluate the effectiveness of the treatment, this reassessment and evaluation is to be documented in the clinical health records.

An interview with an RN #115 and the DOC confirmed that weekly skin assessments are to be completed on residents with skin integrity issues, as well as with residents receiving treatments. The Director of Care acknowledged that the weekly skin assessments for resident #047 were not consistently completed. [s. 50. (2) (b) (iv)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (b), by not ensuring strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Related to Intake # 005306-16, for Resident #049:

Resident #049 has a history that includes cognitive impairment.

Progress notes were reviewed for a specific period and provided details of three separate incidents in which resident #049 exhibited a specific responsive behaviour.

A review of the plan of care, for the period indicated above, fails to provide documented evidence that strategies have been developed to decrease or eliminate resident #049 from exhibiting an identified responsive behaviour.

Registered Nurse #100 and Personal Support Worker indicated that the plan of care for resident #049 currently does not identify strategies to be implemented when resident #049 is exhibiting the said responsive behaviour.

Registered Nurse #100, as well as the Administrator, indicated that new or worsening responsive behaviours are to be identified in the plan of care for each resident and that strategies (interventions) are to developed and implemented as required by staff providing care. [s. 53. (4) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 222. Exemptions, training

Specifically failed to comply with the following:

s. 222. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff who are at the home pursuant to a contract or agreement with the licensee or a contract or agreement between the licensee and an employment agency or other third party, who will only provide occasional maintenance or repair services to the home and will not provide direct care to residents receive the following information before providing their services:

- The Residents' Bill of Rights
- The home's policy to promote zero tolerance of abuse and neglect of residents
- The duty to make mandatory reports
- The whistle-blowing protections under section 26
- Fire prevention and safety
- Emergency and evacuation procedures
- Infection prevention and control, including hand hygiene, modes of infection transmission, cleaning and disinfection practices; and use of personal protective equipment.

Related to intake # 005824-16:

A Critical Incident Report was received on a specific date for a medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

The CIR indicated that on an identified date it was suspected that Registered Practical Nurse (RPN) #135 gave another resident’s medications to resident #052 on a said date.

An interview with RPN #135 indicated that he/she did not receive training in the above identified areas prior to assuming his/her role. [s. 222. (2)]

Issued on this 22nd day of April, 2016

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

Original report signed by the inspector.