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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 22, 30, 2019	2018_749722_0007	026449-18	Resident Quality Inspection

Licensee/Titulaire de permis

Estonian Relief Committee in Canada
40 Old Kingston Road SCARBOROUGH ON M1E 3J5

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

Ehatare Nursing Home
40 Old Kingston Road SCARBOROUGH ON M1E 3J5

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

COREY GREEN (722), JENNIFER BATTEN (672)

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): October 1, 2, 3, 4, 5, 10, 11, and 12, 2018

During this inspection, the following intake logs were inspected:

Log #027197-18 - Complaint related to personal support services, maintenance, falls prevention, and dining supervision

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Activity Manager, RAI-MDS Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Family Council President, residents and family members.

The inspectors conducted a tour of the home; observed infection prevention and control practices, medication administration, staff to resident and resident to resident interactions, and resident home areas; and reviewed clinical health records (electronic and hard copy), staff schedules, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

7 WN(s)
3 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	Légende 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. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all equipment was maintained in a safe condition and in a good state of repair.

Related to Log #027197-18:

An anonymous complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) Action Line on a specified date, related to the maintenance and condition of the shower chairs used in the home.

On a specified date and time, Inspector #672 observed a shower chair in a specified shower room. The chair had a "MedPro Euro" label on the back of the chair, and was metal with a grey seat, and a blue cloth strip across the back. The arm cover on the right side of the chair was missing, and the entire right arm of the chair was observed to be covered in rust with two large bolts sticking up from the arm of the chair. When Inspector #672 touched the right arm of the shower chair, it was noted that there were several sharp pieces of metal within the rusted area, and the two large bolts both had sharp pieces on the top portion of the bolts.

Inspector #672 then observed the shower chairs in another specified shower room. One of the shower chairs was a large black chair, with garbage bags tied around the back and sides of the chair. The seat of the chair and the seat belt were observed to be very dirty, with staining and a large amount of debris caught within the Velcro of the seat belt on the chair.

During an interview on a specified date, PSW #113 indicated being aware that the shower chair from the specified shower room had been missing the arm cover "for a long time", and felt the chair was possibly dangerous for residents to use. PSW #113 further indicated they had worked during a specified period, and had to wrap the entire chair arm in a towel during resident showers, in an attempt to protect the residents from possibly sustaining skin tears or other injuries from the sharp pieces protruding from the chair. PSW #113 indicated they had not reported that the arm cover on the shower chair was broken, and was unaware if the condition of the chair had been reported to the maintenance team or to the DOC by another staff member. PSW #113 indicated the expectation in the home was that maintenance concerns were to be reported to either the maintenance department or to the DOC, immediately upon finding an unsafe or malfunctioning piece of equipment.

During an interview on a specified date, PSW #115 indicated being aware that a shower chair from a specified shower room had been broken, but was unsure for how long the shower chair had been in that condition, due to mostly working in the other specified shower room. PSW #115 further indicated that a shower chair from the other specified shower room had been malfunctioning for a specified period of time, as the chair had not been sitting upright fully, therefore the residents seated in the chair were tilted backwards slightly. The PSW indicated that they struggled to bathe residents appropriately, due to not being able to reach and access the resident's back fully, and residents may slide out of the chair. PSW #115 indicated that this was reported to the DOC, and was informed by the DOC that parts had been ordered to fix the chair, but had not arrived. PSW #115 further indicated that the malfunctioning shower chair had not been removed from the shower room after reporting the concerns to the DOC, and staff continued to use the chair, using garbage bags tied onto the chair to try and hold it in the upright position.

On a specified date, Inspector #672 observed a note taped to the table in the staff room behind the nursing desk, which stated: "Do not tie garbage bags to the shower chairs. MOH saw them, and we can't do that."

During an interview on a specified date, the DOC indicated being aware of a concern with the shower chair in the specified shower room, where the arm cover had been missing. The DOC indicated they had become aware of this issue within a specified period of time and had previously ordered a replacement chair, which had not yet arrived. The DOC attended the specified shower room with Inspector #672, and confirmed the chair was in disrepair, which could possibly cause injury to a resident. The DOC indicated

they should have immediately removed the chair from the shower room, upon becoming aware of the issue several weeks prior. The DOC indicated that they made the decision to allow the shower chair to remain in use, despite the chair not being considered safe, because staff stated that the chair was required when toileting residents in the shower room. Following the interview, the DOC removed the broken shower chair from the shower room. Inspector #672 and the DOC then attended the other specified shower room, and observed the two shower chairs present. The DOC acknowledged that one of the chairs had garbage bags tied to it, would not sit in an upright position, and was not clean. The DOC confirmed that the chair was not considered acceptable for resident use in its current condition.

The DOC indicated that the expectation in the home was that all resident equipment should be well maintained in a safe condition and in a good state of repair at all times, which was not achieved, specifically related to the shower chairs.

The licensee failed to ensure that all resident equipment was maintained in a safe condition and in a good state of repair at all times, specifically related to the shower chairs. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all personal items were labelled with a resident's name within 48 hours of admission and, in the case of new items, of acquiring.

On a specified date, during the initial tour of the home, Inspector #672 observed the following:
- Shower room in specified resident home area: one unlabelled black hair comb sitting on the edge of the sink, and one opened and unlabelled antiperspirant, which appeared to have been used
- Shower room in another specified resident home area: two unlabelled white hair brushes with black bristles and white hairs caught within the brushes, one unlabelled black hair comb, and one opened and unlabelled antiperspirant, which appeared to have been used

During an interview on a specified date, PSW #102 indicated that each resident should have their own supply of personal items, which should be labelled with the resident's name. PSW #102 further indicated that sometimes if staff forget to bring the resident's personal items to the shower room, they would use the items found in the shower room instead, in an effort to try and save time. PSW #102 was unable to indicate who the items identified above belonged to, and threw them all out into the garbage.

On a specified date and time, Inspector #672 observed an unlabelled black hair brush with black and white bristles and white hairs caught in the hairbrush in a specified shower room.

During an interview on a specified date, PSW #112 indicated that each resident should have their own supply of personal items, which should be labelled with the resident's name. PSW #112 further indicated being unaware of who the hairbrush belonged to, but

indicated that periodically staff would use brushes or combs from the shower room, if they didn't have the resident's personal item within reach, in order to assist in saving time.

During an interview on a specified date, the DOC indicated that the expectation in the home was that all personal items should be labelled with the resident's name. The DOC further indicated that it was not acceptable for staff to share personal items for residents, such as hairbrushes, combs, or deodorants for any reason.

The licensee failed to ensure that all personal items were labelled with a resident's name. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all personal items are labelled with a resident's name within 48 hours of admission and, in the case of new items, of acquiring, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that

includes, at a minimum, the following elements: 4. Monitoring of all residents during meals.

Related to resident #002:

Inspector #672 observed resident #002 to be eating the lunch meal in their bedroom on two specified dates, and no staff members were present in the room at the time.

Inspector #672 reviewed resident #002's current written care plan, which indicated that the resident was at high nutritional risk related to identified factors, and had a potential for altered nutrition due to specified medical conditions. The care plan also indicated that resident #002 required a specified level of assistance with meals, required daily monitoring of food and fluid intake, required monitoring for any difficulty eating, and staff were to report to the charge nurse when a specified percentage of the meal was not eaten. One of the goals listed in the care plan was to prevent specified risks related to eating, and required close monitoring during meals.

Inspector #672 then reviewed resident #002's progress notes for a specified period, which indicated that on a specified date, a referral was sent to the Registered Dietitian (RD) for a request to have the resident assessed, related to specified difficulties with eating. Resident #002 was assessed by the RD on a specified date. The RD provided a recommendation for resident #002 to receive a specified diet, and to be monitored during meals for any of the identified risks.

Related to resident #014:

On October 12, 2018, Inspector #672 observed resident #014 to be eating the lunch meal in their bedroom, and no staff members were present in the room at the time.

Inspector #672 reviewed resident #014's current written care plan, which indicated that the resident was at high nutritional risk for specified reasons. The care plan also indicated that resident #014 was at an identified nutrition risk, was not at their ideal body weight, required monitoring for any identified risks associated with eating, required identified support throughout the meal, and staff were to report to the charge nurse when a specified percentage of each meal had not been eaten.

Related to resident #016:

On a specified date, Inspector #672 observed resident #016 to be eating the lunch meal in their bedroom, without any staff members present in the room at the time.

Inspector #672 reviewed resident #016's current written care plan, which indicated that the resident was at moderate nutritional risk for specified reasons. The care plan also indicated that resident #016 was at an identified nutritional risk, required monitoring for any identified difficulties with eating, and staff were to report to the charge nurse when a specified percentage of each meal had not been eaten.

During separate interviews on a specified date, PSWs #111 and #113 indicated that staff provided meals to residents who eat in their bedroom after the meals had been served in the dining room, and only stayed to supervise the resident eating if the resident required physical assistance with their meal. Otherwise, staff would drop the meal tray off to the resident, and return later to pick up the dirty dishes. PSW #113 further indicated that residents were not monitored eating their meals while receiving tray service in their bedrooms due to not having enough staff available to assist in feeding all of the residents who required physical assistance, therefore staff could not be spared to sit in a bedroom to monitor a resident while they ate.

During separate interviews on a specified date, RN #106 and the DOC indicated that the expectation in the home was that every resident who consumed a meal should be monitored by staff at all times, even if they were eating the meal outside of the dining room.

The licensee failed to ensure that residents #002, #014 and #016 were monitored during meals when they were eating in locations other than the dining room. [s. 73. (1) 4.]

2. The licensee failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Related to Log #027197-18:

An anonymous complaint was received by the MOHLTC Action Line on a specified date. The areas of concern related to nutrition and hydration identified within the complaint included the following: not having enough staff members to provide assistance to all residents who required support in the dining room with their meals, and meals being served to residents prior to staff being available to assist, therefore residents were

consuming cold food.

Related to resident #010:

On a specified date, during Stage 1 of the Resident Quality Inspection (RQI), Inspector #672 was observing residents in the dining room during the lunch meal service. At a specified time, Inspector #672 entered the dining room, observed resident #010 to be seated at a dining room table with a meal in front of them, and the resident did not appear to be able to assist in feeding themselves. No staff members were observed to be seated at resident #010's dining table at that time. Inspector #672 observed resident #010 for approximately five minutes. During that time, the resident was observed to be sitting quietly, staring at the plate of food, but not attempting to feed themselves. Inspector #672 observed four staff members in the dining room, all of whom were assisting other residents with their meals. None of the staff members spoke to resident #010, provided any type of verbal encouragement, or interacted with resident #010 in any way. At a later specified time, after being interviewed by Inspector #672, RN #106 provided assistance to resident #010 with the lunch meal after they finished providing assistance to another resident.

At another specified time, during an interview on a specified date with Inspector #672, RN #106 indicated that resident #010 required total assistance with meals from one staff member. RN #106 further indicated that PSW #107 had been assigned to assist resident #010, but was currently busy assisting two other residents with their meals, and would provide assistance to resident #010 when finished with assisting the other residents. RN #106 was unable to indicate at what time the meal had been served to resident #010, or how long the food had been sitting on the table in front of the resident, prior to Inspector #672 observing the plate in front of the resident at a specified time.

Inspector #672 reviewed resident #010's current written care plan, which indicated that the resident was at a moderate nutritional risk and altered nutrition related to a number of specified factors. Inspector #672 reviewed resident #010's most recent RAI-MDS assessment, which was completed on a specified date. The assessment indicated that resident #010 required extensive assistance from one staff member for the task of eating.

Related to resident #011:

On a specified date, Inspector #672 observed the lunch meal in the dining room, and

observed that resident #011 was seated at the dining room table with a meal in front of them. Resident #011 appeared to be sleeping, and not able to assist in feeding themselves. No staff members were observed to be seated at resident #011's dining table. Inspector #672 observed resident #011 for approximately five minutes. Inspector #672 observed four staff members in the dining room at that time, all of whom were assisting other residents with their lunch meals.

During an interview by Inspector #672 on a specified date and time, PSW #112 indicated that resident #011 "usually required" assistance with meals for specified reasons. PSW #112 further indicated that all of the staff members were busy assisting other residents with their meals, and resident #011 would receive assistance with the meal once a staff member became available.

At a later specified time, PSW #111 approached resident #011 and provided verbal encouragement to eat the meal, but did not sit to assist the resident to eat their food. Resident #011 did not awaken or respond to PSW #111 in any way, and the PSW left the resident's table while the food remained in front of the resident. At a later specified time, PSW #111 returned to resident #011's dining table, and provided physical assistance to the resident. Inspector #672 interviewed PSW #111, who was unable to indicate at what time the meal had been served to resident #011, or how long the food had been sitting on the table in front of the resident, prior to Inspector #672 observing the plate in front of the resident at a specified time.

Inspector #672 reviewed resident #011's current written care plan, which indicated that the resident was at moderate nutritional risk and had potential for altered nutrition related to a specified conditions. Inspector #672 reviewed resident #011's most recent RAI-MDS assessment, which was completed on a specified date. The assessment indicated that resident #011 required extensive assistance from one staff member for the task of eating.

During an interview on a specified date with Inspector #672, PSW #113 indicated that the staff would routinely serve meals to residents prior to staff being available to assist the resident. PSW #113 further indicated that there were not enough staff members available in the dining room to meet the resident's needs, which caused the residents to wait a long time for assistance, and/or that some staff members would not provide the resident with enough time to enjoyably consume their meal, and would take the plate away after the resident had only had a bite or two.

During an interview on a specified date, the DOC indicated that the expectation in the

home was that no meals were to be served to a resident who required physical assistance with the meal until a staff member was available to immediately assist the resident.

The licensee failed to ensure that residents #010 and #011 were not served a meal until a staff member was available to provide assistance. [s. 73. (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 that all residents eating in locations other than the dining area are monitored during meals, and residents who require assistance with eating or drinking are only served a meal once someone is available to provide the assistance required, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

During stage 1 of the Resident Quality Inspection (RQI), RPN #110 indicated during an interview with Inspector #722 on a specified date, that resident #005 had an area of altered skin integrity in a specified location, which was verified by Inspector #722 during the resident's census record review on a specified date. These findings triggered for

further inspection.

On a specified date, Inspector #722 reviewed the most recent order provided by the licensee's Nurse Practitioner (NP) for resident #005 related to the resident's treatment for the specified area of altered skin integrity, which indicated two different treatment regimes at two different specified frequencies. The order was signed by the NP, and co-signed by two registered nursing staff.

The electronic treatment administration record (eTAR) for resident #005 was reviewed by Inspector #722 on a specified date, and both treatment regimes specified above were entered on the eTAR. The eTAR entries were initialed by registered nursing staff, which indicated that the specified treatment had been completed, on specified dates and times over specified periods. On specified dates, the eTAR entries indicated that the resident received two different treatments for the area of altered skin integrity on the same day.

RPN #110 was interviewed by Inspector #722 on a specified date, related to the treatment regime for resident #005's identified area of altered skin integrity. During the interview, RPN #110 indicated that the home's NP wrote an order for resident #005's area of altered skin integrity that was flexible, which allowed registered staff to choose the specified product based on availability when the specified treatment was being delivered. The RPN indicated that the treatment was being applied at a specified frequency.

During the interview, RPN #110 indicated that they assessed resident #005's area of altered skin integrity at a specified frequency and, based on specified assessment findings, used either one of the treatments specified by the NP. RPN #110 indicated that they had applied a specified treatment to the area of altered skin integrity on the date the interview was conducted with Inspector #722, and acknowledged that this conflicted with the other specified treatment order written by the NP. RPN #110 indicated that the order for the treatment was confusing, and that they found the treatment orders for the area of altered skin integrity unclear.

Inspector #722 interviewed the DOC on a specified date and time, related to the treatment order for resident #005's specified area of altered skin integrity. During the interview, the DOC reviewed the current written care plan and eTAR for resident #005 and noted that there were two treatments indicated on the eTAR related to resident #005's area of altered skin integrity. The DOC indicated that both active orders looked similar, and that it was unclear which specified treatment and frequency the registered

staff should have been using. The DOC acknowledged that there were two different conflicting orders for resident #005's specified area of altered skin integrity in the plan of care, and that the current orders were not clear as written.

The licensee has failed to ensure that resident #005's written plan of care set out clear directions to staff and others who provided direct care to the resident when the original order, eTAR and current written care plan included two different treatment regimes for resident #005's identified area of altered skin integrity. [s. 6. (1) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or 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, is complied with.

Under O. Reg. 79/10, section 48. (1): Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Under O. Reg. 79/10, section 30. (1): Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs

required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

On October 11, 2018, Inspector #722 reviewed the home's policy (Section 4.0, Subsection 4.16.1) on assessing areas of altered skin integrity, dated April 15, 2013, which indicated the following:
- Policy: Area of altered skin integrity will be assessed at a specified frequency by the registered staff using the specified assessment tool
- Procedure: 1. Registered staff complete the specified assessment tool in the electronic medical record for all specified areas of altered skin integrity, including specified assessment findings.

On a specified date, during stage 1 of the RQI, Inspector #722 reviewed resident #005's electronic health record and recent assessments indicated that the resident had a specified area of altered skin integrity in a specified location. Inspector #722 interviewed RPN #110 on a specified date, who confirmed that resident #005 had the specified area of altered skin integrity, which triggered for further inspection.

The current written care plan and electronic treatment administration record (eTAR) for resident #005 were reviewed by Inspector #722 on a specified date, related to assessments for the specified area of altered skin integrity, which indicated that as of a specified date, the resident was to receive a specified assessment of the area of altered skin integrity at a specified frequency and day.

The specified assessments for resident #005 were reviewed by Inspector #722 on a specified date, related to the specified area of altered skin integrity over a specified period of time, which indicated the following:
- A specified assessment was completed with the appropriate tool, as detailed in the policy above, on specified dates
- A specified assessment was completed with a different specified tool on specified dates
- No formal assessment tool was used for assessments as ordered on specified dates

RPN #110 was interviewed by Inspector #722 on a specified date and time related to the specified assessments for resident #005's area of altered skin integrity. During the interview, RPN #110 indicated they they completed the specified assessment in the

electronic medical record. RPN #110 was not aware that the assessment tool specified in the policy was required for the assessment, and indicated that the registered staff often used another specified tool. RPN #110 confirmed that resident #005's assessments were missing in the electronic medical record for specified dates.

The home's RAI-MDS Coordinator, RPN #118, was interviewed by Inspector #722 on a specified date and time, related to the assessments for resident #005's area of altered skin integrity. During the interview, RPN #118 indicated that the expectation was that the specified assessment tool should be completed at a specified frequency, that the tool is available in the resident's electronic medical record, and that the registered staff should be aware that this is the appropriate tool for assessing the area of altered skin integrity; however, RPN #118 could not recall what the home's policy stated regarding which tool should be used. RPN #118 indicated that other assessment tools should not replace the specified assessment tool for altered skin integrity identified in the licensee's policy. RPN #118 also confirmed that no assessment tool was used to document assessments of altered skin integrity for resident #005 on specified dates.

Inspector #722 interviewed the DOC on a specified date and time related to assessments for resident #005's area of altered skin integrity, and the DOC indicated that the expectation was that the specified assessment tool in the electronic health record was to be used for residents with specified altered skin integrity. The DOC confirmed that the specified assessment tool was not completed for resident #005's altered skin integrity as per the policy on the specified dates when another specified assessment tool was used, and on those specified dates when no formal tool was used.

The licensee failed to ensure that the licensee's policy (Section 4.0, Subsection 4.16.1) on assessing altered skin integrity, was complied with for resident #005's specified area of altered skin integrity when the appropriate assessment tool was not completed for the identified dates. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept locked when they were not being supervised by staff.

On a specified date, during the initial tour of the home at a specified time, Inspector #672 observed that the supply room at the end of an identified hallway could be accessed without entering the code into the keypad on the door. Within the room were supplies which included body cleansers and hand sanitizer; along with cleaning supplies, such as "3M Stainless Steel Cleaner and Polish", bottles of aerosol air freshener, "Oxyvir Tb Surface cleanser", bottles of "Azure All Purpose" surface and glass cleaner, and bottles of "Solutions ES84Neutral" floor cleaner. This was immediately brought to the attention of the DOC, who indicated that the supply room was a non-residential area, and was expected to be kept closed and locked at all times, when not being accessed by staff. The DOC further indicated that the staff would be immediately reminded to ensure that doors to non-residential areas were kept closed and locked at all times when not being accessed by the staff, by ensuring that the locking mechanism was properly set when the staff exited the room.

During an interview on a specified date and time, the DOC indicated that the Environmental Services Manager (ESM) had been called to assess the keypads on each of the doors to the non-residential areas, as all of the locks had the same type of locking mechanism. The locking mechanisms required staff to enter a numerical code into the lock, and then turn the lever to access the room. The DOC indicated that the ESM found there were no mechanical problems with the locks, the issue was related to the staff needing to ensure that the lever was turned all the way after accessing the room, to ensure the lock was reset. The DOC further indicated that all of the staff members had been spoken to, reminding the staff to ensure that the locks were properly reset after accessing the room, to ensure the locks were engaged, to prevent unsupervised access

to non-residential areas.

On a specified date and time, Inspector #672 observed that the shower room in a specified resident home area (RHA) was not locked properly, as the door could be pushed open without entering the code into the keypad. At another specified time, the supply room in another specified RHA was observed to not be locked properly, and the door could still be pushed open without entering the code into the keypad. The DOC was immediately informed of these observations.

On a specified date and time, Inspector #672 observed that the door to the nursing station was not locked properly, and the door could be pushed open without entering the code into the keypad. The nursing station stored the private health information of all of the residents who resided on the unit, and led to the staff room, which housed a fully supplied kitchenette for staff to utilize. At another specified time, Inspector #672 observed that the door to the shower room in a specified area of the home was not locked properly, and the door could be pushed open without entering the code into the keypad.

During an interview with Inspector #672 on a specified date and time, the DOC indicated that the shower rooms and nursing station were considered to be non-residential areas, and the expectation in the home was that the areas were kept closed and locked at all times, when not being accessed by staff.

On another specified date and time, Inspector #672 observed housekeeper #105 cleaning the shower room in a specified RHA. Upon completion, the housekeeper exited the shower room, and did not ensure the lock was properly engaged. Upon inspection, the door was able to be pushed open without entering the code into the keypad.

During an interview on a specified date, with Inspector #672, housekeeper #105 indicated being aware that the lever of the locking mechanism needed to be manually reset, in order for the lock to engage properly, as they had previously complained about the locks not engaging properly to the ESM. Housekeeper #105 further indicated they had forgotten to ensure the door to the shower room in the specified RHA was locked after cleaning and exiting the room, but was aware of the expectation in the home that the shower rooms were to be kept closed and locked at all times, when not being used by staff.

On a specified date and time, Inspector #672 observed staff exiting the nursing station,

and not checking to ensure the locking mechanism was engaged properly. Inspector #672 observed the door to the nursing station, and noted that the lock had not engaged properly, and the door could be pushed open without entering the code into the keypad. At another specified time, Inspector #672 observed the shower room in the specified RHA, and noted that the lock had not engaged properly, and the door could be pushed open without entering the code into the keypad.

During an interview with Inspector #672 on a specified date and time, the DOC was informed of the observations made regarding the doors leading to non-residential areas being left unlocked. The DOC indicated that signs were being posted on each of the doors, to remind the staff about the importance of ensuring the locks were engaged upon exiting the room. The DOC further indicated that a small impromptu meeting had been held with the staff five minutes prior to the interview, where they were also verbally reminded of the importance of ensuring the locks were properly engaged upon exiting any non-residential area.

On another specified date and time, Inspector #672 observed PSW #102 exit the shower room in the specified RHA, and observed that the lock had not engaged properly, and the door could be pushed open, without entering the code into the keypad. During an interview on the same specified date, PSW #102 indicated being aware that the doors leading to non-residential areas were to be kept closed and locked when not in use, and was aware that the locks needed to be manually reset in order for the locking mechanism to properly engage, but had forgotten to do so.

On another specified date, Inspector #672 observed that the locks had not engaged properly and the doors could be opened without entering the code into the keypad in the following non-residential areas: shower room in a specified RHA at a specified time, and the shower room in another specified RHA at another specified time.

On a later specified date, Inspector #672 observed that the locks had not engaged properly and the doors could be opened without entering the code into the keypad to the following non-resident areas:
- At a specified time, nursing station door, as well as the shower room and supply room in a specified RHA
- At another specified time, the shower room in another specified RHA
- At another specified time, the shower room in another specified RHA
- At another specified time, the nursing station door
- At another specified time, the shower room in a specified RHA (after Inspector #672

observed PSW #107 exit the shower room)
- At another specified time, the shower room in a specified RHA

During an interview on a specified date and time, PSW #107 indicated that the shower rooms, nursing station and supply room were considered to be non-residential areas, when staff were not present to supervise. PSW #107 further indicated being aware of the expectation in the home that the doors were to be kept closed and locked at all times, when not in use, but had forgotten to do so, as they were rushing to complete two resident showers prior to the dinner meal.

On another specified date, Inspector #672 observed that the locks had not engaged properly and the doors could be opened without entering the code into the keypad to the following non-residential areas:
- At a specified time, shower room door in a specified RHA
- At two other specified times, shower room door in another specified RHA

On another specified date, Inspector #672 observed that the lock was not properly engaged, and the door could be pushed open without entering the code to the keypad to the following non-residential areas:
- At two additional specified times, shower room in a specified RHA
- At another specified time, the supply room in a specified RHA
- At another specified time, shower room in another specified RHA

During an interview with Inspector #672 on a specified date, the DOC indicated that some staff had been aware that the levers on the bottom of the locks on the doors leading to non-resident areas had not been resetting properly for a while, due to wear and tear, but had not reported or documented this concern. The DOC further indicated that the staff had been reminded to ensure the locks were properly engaged, and to report any concern with the locks or doors to the DOC or ESM immediately.

During an interview on a specified date, the Administrator indicated that a locksmith had been called to the home in the late afternoon on a specified date, to replace the locks on the doors which led to non-residential areas, in an attempt to ensure that the doors would automatically lock upon closing.

During observations made on a specified date, Inspector #672 observed that the same numerical keypad locks, with a turn lever at the bottom had been replaced on the doors to all non-residential areas, and the locks appeared to be properly engaged.

The licensee has failed to ensure that all doors leading to non-residential areas were

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WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances were kept inaccessible to residents at all times.

On a specified date, during the initial tour of the home at a specified time, Inspector #672 observed a specified number of residents sitting in the Solarium, in various specified activities. No staff were observed to be in the area, and Inspector #672 observed the following items on a shelf under the window:
- One bottle of "Wilson Pow-r Gro - Plus 0.1% iron 10-10-10 for potted plants"
- One 500 gram jar of "Kent Marine Superbuffer dKH" which had the following warning on the jar: "Caution, do not taste, swallow or breathe. If in eyes, immediately flush for 15 minutes." The purpose of this product was for adjusting the saltwater in aquariums.
- One 500 gram jar of "Plant Prod House Plant Fertilizer"
- One bottle of "Schultz 8-14-9 African Violet Liquid Plant Food" which had the following warning: "Caution, do not swallow. Keep out of reach of children and pets. Keep bottle tightly closed"
- One 470 millilitre (ml) bottle of "Allergy Relief from Cats - Simple Solution", which had the following warning: "Please keep out of reach of children. In case of eye contact, rinse thoroughly with water"
- One 237 ml bottle of "Schultz Plant Shine Leaf Polish".

During an interview with Inspector #672 on a specified date, Activity Manager #103 indicated that the products were not safe to be left out where they could possibly be accessed by residents, and should have been locked in a cupboard. The Activity Manager further indicated that the items had not been utilized for a long period of time, and was not aware of some of the hazardous substances stored on the shelf.

During an interview on a specified date, the DOC indicated that the expectation in the home was that all potentially hazardous products were to be kept locked in a cupboard or supply room, which could not be accessed by residents at any time.

The licensee failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, when potentially hazardous substances were identified in an open cabinet in a resident home area. [s. 91.]

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 29th day of January, 2019

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

Original report signed by the inspector.