Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 17, 2015	2015_215123_0012	H-002883-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE HALTON HILLS
9 Lindsay Court Georgetown ON L7G 6G9

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

MELODY GRAY (123), DARIA TRZOS (561), KATHLEEN MILLAR (527), THERESA MCMILLAN (526)

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): July 17, 20, 21, 22, 23, 24, 26, 27, 28, 29, & 30, 2015

Concurrent inspections: H-000895-14, H-001072-14, H-001177-14, H-001543-14, H-002080-15, H-002071-15, H-002072-15, H-002073-15, H-002074-15 and H-002075-15

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), registered staff, Director of Care (DOC), Assistant Director of Care(ADOC), Food Services Manager (FSM), Resident Assessment Instrument Coordinator (RAI-Coodinator), Maintenance Supervisor and the Administrator

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

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

12 WN(s)
8 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (7)	CO #004	2014_205129_0017	123
O.Reg 79/10 s. 15. (1)	CO #002	2014_205129_0017	561
O.Reg 79/10 s. 229. (10)	CO #001	2014_205129_0017	123
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_247508_0036	526
O.Reg 79/10 s. 53. (4)	CO #003	2014_205129_0017	123
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #005	2014_205129_0017	527

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out, the planned care for the resident as evidenced by:

The record of resident #400 was reviewed and it was noted that the resident was identified as being at a high risk for choking and required specific interventions to decrease their risk of choking. The resident's written plan of care was reviewed and it did not include any information related to their risk of choking.
The DOC was interviewed and they confirmed that the information related to the resident's risk of choking and the planned care to decrease the choking risk was not included in the resident's written plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident’s care needs changed or care set out in the plan was no longer necessary as evidenced by:

A) Resident #501 fell in June 2014 and was transferred to the hospital. The resident had surgery and was transferred back to the home with specific instructions that precautions must be followed for three months. The resident's record was reviewed and there were no precautions identified in the plan of care. The DOC was interviewed and confirmed that the discharge instructions from the hospital were expected to be followed and included in the plan of care when the resident was re-admitted to the home.

B) Resident #502 had a quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment completed in June 2014. The Resident Assessment Protocol (RAP)identified that the resident was unsafe to ambulate. The resident had received a new wheelchair, which was adjusted to help improve positioning while maintaining their ability to foot propel, and a chair alarm was applied due to continuous attempts to stand and ambulate.
Several PSWs were interviewed and could not recall whether the resident had a chair alarm applied or not. The DOC confirmed that the resident was at high risk for falls and that the plan of care was not revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident: to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the the home was equipped with a resident-staff communication and response system that was easily seen, accessed and used by residents, staff and visitors at all times as evidenced by:

Over a six day period, resident #112's bed station call bell did not activate when the

button was pushed to trigger it. Registered staff confirmed that the resident could use the call bell, that it was not functioning, and followed the home's procedure to replace the faulty cord on July 22, 2015.

The following day, the system did not trigger when resident #112 was observed pushing the button of their call bell. The resident told the inspector that it was often hard to trigger the system. An alternative method for the resident to call for assistance was not observed at the resident's bedside. During interview the Maintenance Supervisor stated that the new call bell cord that was installed one day prior was the wrong one and resident #112's bed station could not be used at least since that time. They stated that an alternative system for the resident to use to call for staff assistance had not been implemented by the home.

The home's Resident Safety/Emergency Procedures policy "Communication Systems-Nurse Call System" number RESI-08-02-01 last reviewed December 2002 was reviewed and it directed staff "Should a call bell be temporarily out of service, measures to provide additional surveillance of residents must be implemented until repairs have been completed". During interviewed the DOC confirmed that staff should have tried an alternative method for the resident to notify staff of their need for assistance. [s. 17. (1) (a)]

2. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, in the case of a system that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff as evidenced by:

During a tour of the home over a six day period in July 2015, it was noted that the resident-staff communication and response system was not equipped with an audio component throughout the corridors to alert staff that a signal had been activated in a resident accessible area. According to the Administrator and Maintenance Supervisor, prior to the summer of 2014, the home was equipped with pagers for staff to wear and audibly alerted staff to an activated station, but were removed from service. At the time of inspection, the audio component was isolated to a digital display marquee suspended from the ceiling near the nurse's station. The marquee was observed to chime in the vicinity of the marquee, but not anywhere else. Registered and non-registered staff interviewed reported that they could not hear the chiming in the corridors and that they were not aware of an active station unless they were at the nursing station when the call bell was activated, or within view of a light illuminated above a resident's room.

Staff would be required to wear their pagers or, since the home has the visual dome lights above the door, additional sound speakers or marquee boards would need to be added to ensure that staff are audibly made aware of the location of the activated signal. [s. 17. (1) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to minimize the restraining of residents was complied with as evidenced by:

The home's policy and procedures Resident Care Quality Indicators: "Physical Restraints" number RESI-10-01-01 effective as of November 2012 was reviewed. The policy directed staff that "Restraint re-assessment shall be completed at a minimum quarterly".

In July 2015 resident #111 was observed to have a lap belt restraint applied loosely as confirmed by registered staff. Review of their health record indicated that the home had completed the "Restraint Assessment 2012" in October 2014, and February 2015. Review of the resident's record revealed that there was no further "Restraint Assessment" completed between February 2015 and July 2015. Registered staff and the DOC confirmed that the restraint assessment had not been completed quarterly according to the home home's "Physical Restraints" policy. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented as evidenced by:

The records of resident #501 and #502 were reviewed and the documentation indicated that the residents were assessed as being at a high risk for falls and that both residents experienced a fall in 2014, which caused a significant injury. The home utilizes the Morse Fall Scale to determine the level of risk for falls. The registered staff were expected to complete the Morse Fall Scale on admission, quarterly and when there was a significant change to the residents' condition. There was no documentation of the Morse Fall Scale being completed for both residents for their last two quarterly assessments. The Charge Nurse and DOC were interviewed and confirmed that the staff were expected to complete and document the Morse Fall Scale assessment when the residents were admitted, quarterly, and when a resident had a significant change to their condition. The DOC confirmed there was no documentation of the Morse Fall Scale in the clinical records of both residents. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to the interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming on a daily basis as evidenced by:

During inspection and observation over a period of seven days in July 2015, resident #101 was observed to be unshaven. The resident stated that they did not like to be unshaven and that it was usually completed in the morning. The Resident Assessment Instrument- Minimum Data Set (RAI-MDA) assessment completed in July 2015, indicated that the resident required extensive assistance from one staff person for personal hygiene including shaving.

The next day, LTC inspector observed the resident to have injuries to their face. During interview the resident stated that their shave was uncomfortable and stated that the wounds resulting from the shave were painful. Review of their health record indicated that they had a health condition that could impede healing.

During interview the PSW who shaved resident #101 stated that the resident required extensive assistance with personal hygiene and that the resident was not able to shave themselves. The PSW stated that the resident's skin was soft and the hair was hard especially if they had not been shaven in a few days. Interview with two other PSWs who had cared for resident #101 described a different shaving technique and stated that they had not experienced the resident #101 being cut during shaving. Resident was observed by LTC Inspector on one day during the seven day period to be clean shaven with no cuts or injury to facial skin.

The home's Resident Care Manual Activities of Daily Living policy "Personal Hygiene/Grooming" number RESI-05-07-06 last reviewed on December 2002 indicated that "Each male resident will be shaved or assisted to shave himself daily unless resident choice is to grow a beard or other routine is established on Care Plan. This care is provided to ensure residents appear well-groomed and to enhance a feeling of self-esteem and well-being".

During interview, the DOC confirmed that the resident had not been shaved daily or according to their preference or needs. The resident preferred to be shaved daily but was observed by the LTC inspector to be unshaven over a three day period. In addition the DOC confirmed the technique used to shave resident #101 on that day did not meet the resident's needs for comfort and well-being. [s. 32.]

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 each resident of the home received individualized personal care, including hygiene care and grooming on a daily basis, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with routine activity of living was included in a resident's plan of care only if all of the following were satisfied: alternatives to the use of the PASD have been considered, and tried where appropriate, but would not be or have not been, effective to assist the resident with the routine activity of living: the use of the PASD was reasonable given the resident's physical and mental condition and personal history and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living; the use of the PASD was approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulations and the use of the PASD was consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent and the plan of care provided for everything required under subsection (5) as evidenced by:

Resident #200 was observed sitting in a tilted wheelchair. A PSW stated that the resident should not have been tilted. An interview with the registered staff indicated that the resident required to be tilted for comfort and positioning.
The written plan of care was reviewed and did not indicate that the resident required to be tilted for comfort. The registered staff confirmed that this was not care planned for resident. The health care records were reviewed and there was no assessment completed to determine if the tilted wheelchair was used as a PASD or restraint, there was no approval for the tilt wheelchair and no consent was obtained from the resident's substitute decision-maker.
The Assistant Director of Care (ADOC) confirmed that the resident required the wheelchair to be tilted for comfort and positioning; confirmed that there was no assessment completed to determine whether the tilt wheelchair was being used as a PASD or restraint and there was no approval or consent obtained from the substitute decision-maker. [s. 33. (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 that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 3. The use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 5. The plan of care provides for everything required under subsection, to be implemented voluntarily.

WN #7: 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 failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and was assessed by a registered dietitian who was a member of the staff of the home as evidenced by:

Resident #101 was observed to have the following injuries to their face.

During interview the part-time PSW who shaved resident #101 on that day, stated that the resident required extensive assistance with personal hygiene and that the resident was not able to shave themselves. The PSW stated that the resident’s skin was soft and the hair was hard.

Review of resident's record indicated that a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment was not completed and a dietary referral had not been made upon registered staff becoming aware of resident #101’s facial wounds.

During interview a RPN and the ADOC confirmed that resident #101 had not received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, and was not assessed by a registered dietitian who was a member of the staff of the home regarding altered skin integrity. [s. 50. (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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds; receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and 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 , to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that training was provided to all staff who provide direct care to residents in falls prevention and management as evidenced by:

The direct care providers were interviewed and they were not able to recall when they were last trained in Falls Prevention and Management. The DOC confirmed they usually train all direct care providers in Falls Prevention annually. The DOC provided their training records and confirmed they trained 29% of their staff in 2014. The licensee failed to provide annual training to direct care providers in the required program of Falls prevention and management. [s. 221. (1) 1.]

2. The licensee failed to ensure that all staff who provide direct care to residents received received annual training in all the areas required under subsection 76 (7) of the Act as evidenced by:
The home's 2014 annual education records were reviewed and it was noted that the mandatory training and or education was not provided to the staff who provided direct care to residents. The ADOC was interviewed and they confirmed that in 2014, the staff who provided direct care to residents did not receive annual training in all required areas. [s. 221. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following are other areas in which training shall be provided to all staff who provide direct care to residents: 1. Falls prevention and management and to ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odors as evidenced by:
Over a six day period in July 2015, an offensive urine odor was noted in the television lounge on Wildwood House resident care area. The home's Housekeeping and Laundry policy "Odours" number HKLD-05-03-08 effective as of September 2013, directed staff to identify the source of the odor issue and to use the Odor Control Monitoring Tool (Appendix 1) to help with this. If unable to find the source of odor, staff were directed to review the area with odour issues at various times of the day to establish if the odor was ongoing; to investigate the cause of the unacceptable lingering odor through looking at process, procedures, systems and if required, repeat the review of the area in one to two weeks to identify change and or repeat investigation if change was not successful.

During interview, the Environmental Supervisor stated that the home's expectation was to address the underlying cause of the odor if possible, and this may include cleaning carpets, furniture or identifying a particular resident associated with the odor. The Environmental Supervisor stated that they were aware of the odor in the Wildwood television lounge since a staff person had verbally reported it approximately one week earlier. Even though the supervisor reported that they did not detect an odor at that time, and the "Odor Control Monitoring Tool" was not initiated, and the area was not monitored at different times of day as noted above according to the home's policy.

The supervisor stated that the expectation of housekeeping staff was to conduct a "special cleaning" of all lounge areas every week and that odors could be identified and dealt with at that time. Review of the sign off sheets completed by housekeeping staff for May, June and July, 2015, indicated that the Wildwood lounge had not had "special cleaning" weekly according to the home's policy. Housekeeping staff and the Environmental Supervisor confirmed this. [s. 87. (2) (d)]

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

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the physical device was applied in accordance with the manufacturer's instructions as evidenced by:

The home's Resident Care and Quality Indicators policy "Physical Restraints" number RESI-10-01—01 directed staff to check the resident least every hour to ensure that

resident comfort and safety including that the restraint was applied appropriately. The manufacturer's instructions for the application of lap belts provided by the home instructed staff "to be effective, any belt must be not loose to allow client to slide under belt, nor too tight to irritate boy prominences or soft tissue. (Just enough space for two fingers to fit between the belt and pelvic crest)". The DOC confirmed that the home's expectation is that lap belts be applied within two finger widths from a resident's torso.

A) The LTC inspector observed resident #200 sitting in a wheelchair with a lap belt applied that was positioned at least six inches from the resident's torso. When asked, a Registered Practical Nurse (RPN) confirmed that the lap belt was loose and tightened it so that it was less than two finger widths from the resident's torso. They indicated that they would adjust it to two finger widths when the resident was out of the chair. Review of the resident #200's plan of care indicated that the lap belt was applied as a restraint. During interview, the DOC confirmed that a lap belt that was applied greater than two finger widths from the resident's torso was not applied according to manufacturer's instructions or the home's expectations.

B) B. Resident #200 did not have a front-fastening seat belt applied according to manufacturers instructions. Resident #200 was noted to be sitting in a wheelchair with a front fastening seat belt applied and it was noted that there was a six inch gap between the resident's body and the seat belt. A PSW providing care to the resident confirmed that seat belt was not properly applied and was too loose. The registered staff confirmed that all seat belts should be applied so that there is just enough space for two fingers to fit between the seat belt and the resident.

C) Resident #111 was observed sitting in a wheelchair with a lap belt applied that was positioned at least six inches from the resident's torso. When asked, a Registered Practical Nurse (RPN) confirmed that the lap belt was loose and tightened it so that it was approximately two finger widths from the resident's torso. The RPN and review of the resident's plan of care confirmed that the lap belt was applied as a restraint. During interview, the DOC confirmed that a lap belt that was applied greater than two finger widths from the resident's torso was not applied according to manufacturer's instructions or the home's expectations. [s. 110. (1) 1.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the following were documented: 5. The person who applied the device and the time of application; 7. Every release of the device and all repositioning; 8. The

removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care as evidenced by:

Over a ten day period, resident #111 was observed sitting in a wheelchair with a front fastening lap belt applied. On one occasion the resident was observed to have a lap belt restraint applied loosely as confirmed by registered staff.

The home's Resident Care Quality Indicators policy "Physical Restraints" number RESI-10-01-01 effective as of November 2012 directed "care staff" to "Ensure the Restraint Record is completed. Monitoring of restraint use must be completed with hourly safety checks and two hourly position changes which requires the release of the restraint and documented on the restraint record or in e-documentation (i.e. Point of Care tablet task)".

During interview, PSW staff confirmed that they conducted at least hourly restraint and safety checks on the resident #111. Review of the resident's health record indicated that monitoring for restraint use between October 2014 and July 2015, had not been documented including the person who applied the device, the time of application, every release of the device and all repositioning, and the removal of the device including time of removal and post-restraining care.

During interview, the RPN confirmed that the above documentation had not been completed as the question had not been entered into Point of Care (POC) for completion by the PSW. During interview, the DOC also confirmed that resident #111's restraint monitoring had not been documented. [s. 110. (7)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart,
iv. that complied with manufacturer's instructions for the storage of the drugs as evidenced by:

On July 24, 2015 during the tour of the medication rooms with the DOC, the LTC inspector found two medications that were expired in a cabinet where the home kept the government stock medications. One bottle of tablets had an expiry date of March 2015 and another bottle of tablets had an expiry date of November 2014.
The DOC confirmed the expiry dates and disposed of the expired medications. [s. 129. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use as evidenced by:

The LTC inspector observed a medication room that was unlocked and door was approximately quarter of the width open. Medications to be disposed of, government stock medications and a fridge that held insulin were stored in the medication room. A maintenance worker was working on a ceiling repair beside the medication room. The LTC inspector stood at the door for about four minutes until registered staff came into the nursing station. Registered staff confirmed that the medication room should have been closed and locked. [s. 130. 1.]

Issued on this 23rd day of November, 2015

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

Original report signed by the inspector.