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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Sep 1, 2015	2015_337581_0014	H-002977-15	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 HAMILTON
90 CHEDMAC DRIVE HAMILTON ON L9C 7S6

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

DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528), LEAH CURLE (585)

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 28, 29, 30, 31 and August 5, 6, 7, 11, 12, 13, 14, 17, 2015.

This inspection report includes the inspections completed related to H-001634-14, H-002768-15, H-002916-15, H-002092-15 and follow up H-001989-15

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Physiotherapist Assistant (PTA), Program Manager, Food Service Manager (FSM), Registered Dietitian (RD), Program Manager, Environmental Manager, Maintenance staff, Director of Care Clerk, Dietary Aides, Housekeepers, families and residents. The inspectors during this inspection toured the home, observed meal service and care practices, reviewed clinical health records and relevant policies and procedures.

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

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

19 WN(s)
10 VPC(s)
3 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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

Findings/Faits saillants :

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

A) On August 6, 2015, while sleeping in bed, a fall mat was observed beside resident #20's bed. Review of the written plan of care did not include a fall mat. Multiple PSWs reported the resident used the fall mat when in bed. The RPN reported the mat was used for safety and confirmed the written plan of care did not set out the planned care for the resident for the use of a fall mat.

B) Resident #60's clinical records identified they were incontinent of bowel, as evidenced

by completed flow sheets, a bowel continence assessment and Minimum Data Set (MDS) assessment. Interviews with PSW's familiar with the resident reported they were incontinent of bowel and required total assistance from staff. Review of the written plan of care did not set out planned care for the resident related to bowel continence, which was confirmed by registered staff.

C) Throughout the course of the inspection, resident #13 was observed to have facial hair covering their chin and stated they wanted their facial hair removed. The plan of care for resident #13 identified the resident required extensive assistance with part of their personal hygiene as evidenced by cognitive impairment related to dementia and directed staff to use guided maneuvering but was not specific to shaving of facial hair. Review of the flow sheets for personal hygiene did not include any documentation that the direct care staff assisted the resident with shaving for two weeks during the inspection. In an interview with PSW staff on August 12, 2015, they confirmed the resident had been assisted to shave their facial hair in the past but could not recall when it was last completed. The plan of care did not include the planned care for the resident related to shaving preferences and the assistance required. (528) [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of the resident.

Resident #20's plan of care indicated staff were to provide oral care at scheduled frequencies, morning and night and to remove and soak their dentures every night. The resident stated they preferred keeping their dentures in their mouth overnight. A PSW reported the resident slept with their dentures in and never soaked them overnight. Registered staff confirmed they liked to keep their dentures in, did not always get soaked due to their preference and the plan of care was not based on the needs and preferences of the resident. [s. 6. (2)]

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

A) The plan of care for resident #18 identified that the resident required a table top tray as a PASD, to assist the resident with food and fluid intake. On July 31, 2015, the resident did not have a table top placed on their wheelchair during breakfast service. Interview with the PSW and the RPN confirmed that the table top was to be applied for meals and was not applied as specified in the plan of care.

B) Resident #61 had a plan of care to receive pudding thick fluids, as they had swallowing difficulties related to dysphagia, as evidenced by coughing at meals and received a nutritional supplement.

i) On July 30, 2015, during lunch meal service, resident #61 was observed drinking their nutritional supplement which was not thickened and puree soup, which was nectar consistency. The resident had a wet cough after consuming the fluids and was coughing repeatedly throughout the meal. The dietary aide reported the resident required pudding thick fluids and confirmed they served regular puree soup. The RPN who provided the supplement confirmed the resident required thickened fluids and was not served a thickened nutrition supplement.

ii) On August 5, 2015, during lunch meal service, resident #61 received puree soup and coffee, both prepared to a nectar consistency. The PSW who provided the coffee confirmed the resident required pudding thick fluids. The resident was observed consuming their nutritional supplement, which was thickened but lumpy. The resident had a wet cough after consuming the fluids and was coughing repeatedly throughout the meal service. The FSM confirmed the supplement was lumpy and not prepared and served according to the resident's care needs. The Registered Dietitian stated the resident was to receive pudding thick fluids for all fluids, including soup and fluid supplements and confirmed the care set out in the plan of care was not provided to the resident as specified in the plan. (585)

C) The plan of care for resident #44 identified the resident was frequently incontinent and interventions included but were not limited to extensive assistance of two staff for toileting the resident in the morning, before lunch, before dinner, at bedtime and as needed. On August 11, 2015, the resident was observed from 1530 hours to approximately 1800 hours seated in their wheelchair and incontinent odours were noted. The resident was escorted to the dining room for dinner at approximately 1645 hours without being toileted. After dinner service, interview with PSW confirmed that the resident was not assisted to the toilet as outlined in the plan of care. (528)

D) In February 2015, resident #80 fell and sustained an injury. In December 2014, the Physiotherapist assessment identified the resident was a two person assistance for walking with a rollator walker and the wheelchair behind them. Interview with the PSW who provided care on the day of the fall stated they walked the resident in their room and to the washroom with their rollator walker with one person extensive assistance. The ADOC stated that the PSW's were to follow the written plan of care by the

Physiotherapist related to walking the resident and confirmed that the plan of care was not provided to the resident as specified in the plan. (581) [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Review of the plan of care for resident #17 indicated they wore hearing aids when awake. Interview with the PSW stated they did not have hearing aids. Registered staff confirmed that the resident did not wear hearing aids as they were lost several months ago and the written plan of care was not reviewed and revised when the care set out in the plan was no longer necessary.

B) Review of the plan of care for resident #17 indicated they would choose whether they wanted to wear underwear or a pull up and that the family would help to supply pull ups. Interviews with the PSW's stated that the resident wore pull ups on all three shifts, no longer wore their own underwear and the pull ups were supplied by the home. Registered staff confirmed the resident only wore pull ups supplied by the home and the written plan of care was not reviewed and revised when their care needs changed.

C) On July 28, 2015, resident #63 was observed receiving multiple courses at the same time during lunch. Review of the dietary kardex in the servery did not indicate the resident was to be served courses together. The dietary aide reported the resident's care needs were to receive multiple courses together. The RD confirmed the dietary kardex was not updated when the resident's care needs changed. (585)

D) On July 30, 2015 and August 5, 2015, resident #21 was observed in a tilted wheelchair with foot rests.

i) The resident's plan of care was reviewed and indicated they ambulated independently, required physical assistance in a wheelchair and may be able to foot propel for short distances. PSWs reported they were no longer walking, required use of a wheelchair for approximately six months and were unable to foot propel for approximately three months. Registered staff confirmed the resident was now in a tilted wheelchair and that the plan of care had not been reviewed and revised when their care needs had changed.

ii) The resident's plan of care was reviewed and indicated they may transfer independently but may also require one or two person physical assist. Multiple PSWs

reported that they were unable to transfer independently and required two person physical assistance for several months. Registered staff confirmed the resident could not self-transfer, required two person assistance by staff and the plan of care had not been reviewed and revised when their care needs had changed. (585)

E) In June 2015, resident #41 displayed new responsive behaviours towards a co-resident. Immediate interventions put in place included, but were not limited to, one to one monitoring of the resident. Review of the plan of care nine weeks after the incident identified that the resident remained on one to one monitoring, which was not observed throughout the course of the inspection. Interviews with PSW and registered staff revealed that the resident was relocated to a different nursing home area. Since no further responsive behaviours were noted, one to one monitoring was no longer in place; however, the plan of care was not revised. (528)

F) Review of the plan of care for resident #16 indicated they were extensive assistance with two staff for all transfers including toileting. Interviews with PSW's stated the resident was transferred with a sit and stand lift as they were too difficult to transfer with two staff. Registered staff confirmed that the resident was transferred with a sit and stand lift and the plan of care was not reviewed and revised when their care needs changed.

G) Review of the plan of care for resident #16 indicated the resident was positioned in a specialized wheelchair. The resident was observed on multiple days during the course of the inspection sitting in a tilted wheelchair. Registered staff confirmed the resident was sitting in a tilted wheelchair and the plan of care was not reviewed and revised when their care needs changed.

H) Review of the plan of care for resident #16 indicated the resident was returned to bed after lunch to help relieve pressure to their buttocks and coccyx. The resident was observed on multiple days during the course of the inspection sitting in their tilted wheelchair in late afternoon. Interview with PSW stated the resident did not go back to bed after lunch as they were high risk of falls and they tried to climb out of bed. Review of the Turning and Positioning Record indicated for the month of July and August 1,2,3 and 4, 2015, that the resident was up in their wheelchair from 0700 to approximately 2100 hours. Registered staff confirmed the written plan of care was not reviewed and revised when their care needs changed.

I) Review of the plan of care for resident #16 indicated the resident had full bed rails on

the left side of their bed which were raised when the resident was in bed. Resident's bed was observed with two rotating assist rails and a PSW stated they were in the guard position when the resident was in bed. Registered staff confirmed the resident had two assist rails on their bed rails and the written plan of care was not reviewed and revised when their bed rails changed.

J) Review of the plan of care for resident #12 indicated the resident wore a medium size brief. Interviews with the resident and PSW's stated they wore a pull up during the day and evening and a brief at night. Registered staff confirmed that the written plan of care was not reviewed and revised when their continence care needs changed.

K) Review of the plan of care for resident #12 indicated the resident was a two person physical assistance for transfers. Interviews with the resident and PSW's stated they were a one person extensive assistance for transfers. Registered staff confirmed that the resident was no longer a two person transfer and the written plan of care was not reviewed and revised when their care needs changed.

L) Resident #10 had several unwitnessed falls from January to June 2015. Review of the plan of care identified that the resident was a high risk for falls and interventions included but were not limited to, one hour safety checks. Interview with PSW revealed that due to disease progression and both cognitive and physical decline, the resident was confined to a wheelchair and no longer required safety checks. Interview with registered staff confirmed that the plan of care was not revised when the resident no longer required hourly safety checks. (528)

M) Review of the MDS Kardex for resident #80 indicated they would walk in the corridor with limited assistance. Interview with the Physiotherapist Assistant and review of the written plan of care identified the resident was walked with two person assistance and with the wheelchair behind them. The RAI Coordinator confirmed that the plan of care was not reviewed and revised when their ambulation needs changed. [s. 6. (10) (b)]

5. 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, care set out in the plan had not been effective.

The plan of care of resident #18 identified the resident had ongoing issues with altered skin integrity, interventions included but were not limited to, encouraging the resident to return to bed after lunch to offload tissue pressure. In June 2015, registered staff

documented that the resident often declined to go to bed after lunch and the tilt wheelchair was to be used to shift resident's weight and reduce pressure. The written plan of care was not updated to include the new intervention of using the tilt wheelchair to offload tissue pressure, as confirmed by registered staff. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident is reassessed and the plan of care reviewed and revised at any time when the resident's care needs change or 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified day in February 2015, resident #80 was standing with their rollator walker after being toileted with extensive assistance of one staff. According to the progress notes the PSW turned their back to the resident to pick an item up off the floor and the resident fell and was transferred to hospital. Review of the plan of care indicated that the resident was extensive assistance with one person physical assist for all transfers including toilet use. Review of the PSW flow sheets from December 2014, to February 2015, revealed the resident was transferred from bed, chair or standing position with extensive assistance (staff provide weight bearing support) and one person physical assistance. The physiotherapist assessment and written plan of care indicated that the resident was transferred with one person assistance and was walked in the corridor with assistance of two persons and the wheelchair behind. Interview with the PSW who was providing care when the incident occurred stated that the resident was standing with their rollator walker and lost their balance and fell. PSW confirmed they were not providing any physical assistance to the resident when they bent over to pick an item up off the floor and the resident's wheelchair was not in the bathroom at the time of the fall. The ADOC confirmed that the PSW did not provide extensive assistance when transferring the resident at all times and that staff did not use safe transferring when assisting resident #80. [s. 36.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with prevailing practices, to minimize the risk to the resident.

The following residents had not been assessed according to prevailing practices adopted by Health Canada in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" developed by the US Food and Drug Administration, which outlined that decisions to use or to discontinue the use of a bed rail would be made in the context of an individualized patient assessment using an interdisciplinary team with input from the patient and family or the patient's legal guardian.

A. The MDS Kardex for resident #12 identified that they required, " bed rails for bed mobility or transfer". On an identified day in August 2015, two three quarter bed rails were removed from the resident's bed and inspector observed two rotating assist rails on the bed in the transfer position. Review of the plan of care did not include an assessment of either bed rails used on their bed. Interview with the resident revealed they preferred one three quarter bed rail on the right side raised when in bed for turning, positioning and safety. Interview with the Environmental Manager confirmed that resident #12's bed rails were changed in August 2015, as they failed potential zones of entrapment. Review of the bed entrapment worksheet indicated that in April 2015, the resident's bed system failed zone two for potential entrapment with the two three quarter bed rails raised on the bed and did not include an assessment for any zones of entrapment for the new assist rails. The ADOC confirmed that there was no formalized

assessment completed for resident #12 related to the use of bed rails nor was there an assessment completed for the potential zones of entrapment related to the new rails.

B. On an identified day in August 2015, resident #17's bed rails were changed from two three quarter bed rails to two rotating assist rails. Review of the plan of care revealed the resident used two three quarter bed rails for bed mobility, transfer and for safety as requested by family; however, the plan of care did not include a bed rail assessment for the new assist rails on their bed. Review of the bed entrapment worksheet from April 2015, identified that the resident's bed system failed zone two for entrapment with two three quarter rails raised on the bed and were not retested for potential zones of entrapment when the new rails where installed on the bed. Interview with ADOC and Environmental Manager confirmed there was no formalized assessment completed for resident #17 related to the use of the new bed rails nor was there an assessment completed for the potential zones of entrapment.

Furthermore, the ADOC confirmed that on an identified day in August 2015, bed rails where changed or removed on seven resident's beds and no formalized bed rail assessments were completed to determine if bed rails were required or not. [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Throughout the course of this inspection it was identified that resident #12 required one three quarter bed rail raised when in bed for turning, positioning and safety. Review of the home's Bed Entrapment Worksheet, dated April 2015, revealed that the resident's bed system bed failed zone two. Interview with the Environmental Manager confirmed that no interventions were put in place to mitigate the risk for zone two to prevent entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #4: 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 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.

During the initial tour of the home the following was observed:

i) The call system by the shower in Battlefield Spa room did not have a cord attached to the point of activation.

ii) When the call system by the shower area in Edgemount Spa room was pulled, the cord popped off and the call system was not activated.

Interviews with PSWs on the above home areas confirmed that pull cords were to be in place and attached. Interview with the Environmental Manager confirmed that the call system at each point of activation was to include a pull cord for easy access and use by residents, staff, and visitors at all times. [s. 17. (1) (a)]

2. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

During an initial tour of the home on July 28, 2015, five outdoor areas were observed without a communication and response system, including home areas in Aberdeen, Battlefield and Concession, as well as a balcony on the second floor and outdoor terrace area at the front entrance. During the course of the inspection, residents were observed using the outdoor areas. Maintenance staff confirmed the areas were accessible and used by residents and did not contain communication and response systems. [s. 17. (1) (e)]

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 is easily seen, accessed and used by residents, staff and visitors at all times and is available in every area accessible by residents, to be implemented voluntarily.

WN #5: 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. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

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 a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Throughout the course of the inspection, resident #21 was observed sitting in tilted wheelchair. Interview with direct care staff revealed that the resident used the tilt chair for positioning; however, review of the plan of care did not identify that the resident used a tilt chair. Interview with registered staff confirmed that the seat belt was used for positioning, comfort, and safety, but was not included in the plan of care. [s. 33. (3)]

2. The licensee failed to ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following were satisfied:

1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #19 was observed sitting in their tilt wheelchair in a tilted position on July 30, 31 and August 5, 2015. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the tilt wheelchair, nor any documented consent or approvals for its use. The registered staff confirmed that the resident's tilt wheelchair was not assessed to determine if it was being used as a PASD or a restraint nor did they have documented consent or approval for tilt wheelchair in place. [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 a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #6: 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 ensure that, for each resident that demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions.

In June 2015, resident #43 expressed concerns of resident #41's wandering behaviours. Three days later, resident #42 reported to staff that resident #41 had entered their room overnight and displayed responsive behaviours.

i) Review of the progress notes after the responsive behaviour identified that staff were to monitor resident #41 "closely". That evening resident #43 reported to staff that the resident #41 had continued to enter their room and was concerned for their safety.

ii) The home's policy for Responsive Behaviour #09-05-01, last revised September 2010, indicated that when a responsive behaviour occurred, a more indepth assessment of the behaviour would be undertaken using any one or combination of the following assessments: Cohen Mansfield Agitation Inventory, Dementia Observation Scale, Responsive Behaviour Record, or tool used by local psychogeriatrician.

iii) Review of resident #41's plan of care did not include additional assessment of the behaviour and Dementia Observation System (DOS) charting did not begin until six hours after resident #43 reported that the resident continued to wander into their room, approximately 24 hours after the incident of responsive behaviours.

iv) Interview with the ADOC confirmed assessment of the resident's responsive behaviour, including but not limited to, the DOS charting, was not initiated until approximately 24 hours after the responsive behaviour incident. [s. 53. (4) (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, for each resident that demonstrates responsive behaviours, 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

On July 30, 2015, during lunch meal service, puree beans and wieners were served and was pooling on plates. A dietary aide reported the items appeared runny.

On August 5, 2015, during lunch meal service, puree bread was served and observed running on the plate. The FSM reported the item did not hold its shape.

The FSM confirmed puree items should be consistent in texture and hold its shape to preserve taste, nutritive value, appearance, food quality and safety. [s. 72. (3) (a)]

2. The licensee failed to ensure that all food in the food production system was served using methods to prevent contamination.

On July 28, 2015, during lunch meal service, a dietary aide was observed clearing and wiping down soiled tables, wearing rubber gloves. The dietary aide then proceeded to serve resident #65 dessert, handling the dish and clean spoon, still wearing the soiled gloves. The dietary aide reported the home's expectation would be to perform hand hygiene before serving a course and touching clean dishware and this was confirmed by the FSM. [s. 72. (3) (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 food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality and that all food in the food production system are served using methods to prevent contamination, to be implemented voluntarily.

WN #8: 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

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: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's dining and snack service included proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

A) During breakfast service on July 31, 2015, resident #40 was observed to be seated in their wheelchair with tilt feature activated. While the resident remained in the tilted position, the PSW fed the resident cereal. Review of the plan of care identified that the resident required extensive assistance with eating and positioning. Interview with PSW staff confirmed that the resident was not in a safe position for feeding. At that time, the PSW released the tilt and the resident was placed in a upright position for the remainder of the breakfast meal.

B) During dinner service on August 11, 2015, resident #16 was observed to be slouched in their wheelchair with the back of the chair tilted, resulting in the resident's collar bone resting at the height of the dining table. The resident was not attempting to feed themself and staff was feeding the resident spoonfuls of their entree. Interview with staff assisting the resident, identified that the resident was not in a safe position for eating. Two PSWs repositioned the resident in their wheelchair and placed the chair in an upright position, the resident was overheard saying thank you and began to feed themself. Review of the plan of care for the resident identified that the resident was at risk for choking and required extensive assistance with eating when tired; however, participated with food and fluid intake. During dinner service the resident was not seated in a safe position for

eating. [s. 73. (1) 10.]

2. The licensee failed to ensure that there was appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents.

i) On July 30, 31, and August 5, 2015, resident #62 was observed eating, sitting low, with their upper chest parallel to the table and arms directed up to reach items on the table. The resident reported they found eating uncomfortable and they were sitting too low.

ii) On August 5, 2015, resident #20 was observed eating soup, and positioned far and low from the table, with their upper chest parallel to the table top. When asked if they felt the table was too high, the resident responded 'yes'.

On August 5, 2015, a PSW stated the tables appeared low for the residents. The FSM was interviewed and reported the tables could be adjusted; however, confirmed that they were at an inappropriate height during meal service. [s. 73. (1) 11.]

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's dining and snack service included proper techniques to assist residents with eating, including safe positioning of residents who require assistance and to ensure there is appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents, to be implemented voluntarily.

WN #9: 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. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instruction.

On July 30, 31, August 5 and 11, 2015, resident #17 was observed sitting in their wheelchair with a lap belt applied four to five finger widths from their torso. Registered staff confirmed the lap belt was too loose and was not properly applied according to manufacturer's instructions. [s. 110. (1) 1.]

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

Resident #17 was observed sitting in their wheelchair on July 31, 2015, from approximately 0800 hours to 1100 hours with their lap belt fastened and was not released and repositioned. The plan of care indicated that the resident required the lap belt as a restraint. Review of the home's Restraint Record for July 2015, indicated that the lap belt was applied and safety checks were completed but the device was not released during the day shift. Interview with the PSW confirmed that the resident's lap belt was not released and the resident repositioned during the three hour observation period. The ADOC stated that all residents that were restrained needed to be released and repositioned every two hours. [s. 110. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the physical device is applied in accordance with the manufacturer's instruction and that staff release the resident from the physical device and reposition at least once every two hours, to be implemented voluntarily.

WN #10: 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 failed to ensure that drugs stored in an area or a medication cart were secured and locked.

A) On July 30, 2015, during breakfast service, a medication cart was noted to be unlocked and unattended. Residents were seated in the dining room eating breakfast within close proximity to the medication cart. At approximately 0840 hours, the medication cart was unlocked with the keys sitting on the cart and the RPN was in the dining room administering medications to a resident. The Inspector was able to open and close medication cart drawers without registered staff being aware. When the RPN returned to the cart, approximately two minutes later, they confirmed that the cart was left unlocked and was not attended. The RPN also confirmed that the cart should have been locked when unattended.

B) On August 11, 2015, at approximately 1700 hours, the RPN was observed administering medications in the dining room. The medication cart was around the corner and midway down a hallway, unlocked and unattended. The inspector was able to open and close drawers without the RPN aware. When the RPN returned to the cart, they confirmed that the cart should have been kept locked and secure when unattended.

C) On July 28, 2015, at approximately 1245 hours, a medication cart was found unlocked in front of the nursing station. A RPN was distributing medications throughout the dining room, and left the cart unlocked during the medication pass. The inspector was able to open and close medication cart drawers without the nurse being aware. Interview with the registered staff confirmed the medication cart should be locked when unattended. (585) [s. 129. (1) (a) (ii)]

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 drugs stored in an area or a medication cart are secured and locked, 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 ensure that staff participated in the implementation of the infection prevention and control program.

A) The home's "Hand Hygiene Program: #02-01-06", revised January 2015, required all staff who provided care to perform hand hygiene, including but not limited to: before and after contact with any resident, their body substances or items contaminated by them, after assisting resident with personal care, after touching any high touch surface such as keyboards, door knobs, elevator buttons, touch screens (Point Click Care tablet and electronic medication administration record screens).

On July 30, 2015, an RPN was observed administering medications to residents during breakfast. During the observation, the RPN provided medication to three residents, touching resident's utensils, their glasses, patting resident's shoulders and using the medication cart eMAR screen between residents. At no time during the observation did the RPN perform hand hygiene, as required in the home's policy. Interview with registered staff confirmed hand hygiene was to be completed before and after administering medications to residents.

B) The home's policy, "Aro-Clostridium Difficle, Policy #INFE-05-01-01", effective January 2013, outlined that upon notification of a new case of loose stool/diarrhea, registered staff were to assess the resident and should no apparent reason for loose stool/diarrhea be found, assess and determine if they may have Clostridium Difficle (C. Diff), through presentation of new onset of diarrhea (three or more loose or watery bowel movements in a 24 hour period), not customary for the resident and if there was no known reason for the watery bowel movement, such as use of laxative, new antibiotic, or other medication. The policy also stated that if it was determined that the resident may have C. Diff, registered staff would implement contact precautions immediately.

Resident #60's clinical record was reviewed and identified that on an identified day in 2015, they had three new incidents of new loose stools in over 24 hours. The resident continued to have loose multiple stools over each 24 hour period for five days, as

indicated in flow sheets and progress notes. On another occasion in 2015, loose stools continued as per clinical documentation, at which time family requested C.Diff testing. On an identified day in 2015, it was confirmed they were positive for C. Diff, and the home initiated contact precaution measures. Registered staff reported that residents with loose stools would be assessed and put on contact precaution if C. Diff was suspected. Interview with the ADOC confirmed that the resident would have been tested within a couple of days of presenting loose stools and placed on contact precaution prior to the confirmation of presence of C. Diff, which did not occur, as required in the infection prevention and control program. (585) [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 that staff participated 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. 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy "Falls Prevention and Management Program, #RESI-10-02-01", last revised April 2013, stated that if a resident remains in the home after a fall, registered staff were to complete ongoing assessment of the resident for a minimum of 72 hours after the fall and document the assessment in the progress notes.

From January to June 2015, resident #10 had several unwitnessed falls with no injuries noted. Review of the plan of care identified that registered staff assessments were not documented every shift for a minimum of 72 hours as follows:

i) Following a fall in January 2015, a shift assessment was not included in the progress notes from the evening shift on the day following the fall.
ii) Following a fall in March 2015, a shift assessment was not included in the progress notes from the day shift on the second day following the fall.
iii) Following a fall on days in May 2015, a shift assessment was not included in the progress notes from that same evening.

Interview with the RPN confirmed that the assessments were missing from the progress notes as outlined above and therefore documentation was not completed as required in the home's policy. (528) [s. 8. (1) (b)]

WN #13: 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.

Resident #60's plan of care stated they were to receive a bath twice a week. PSW flow sheets over a five week period from October 25, 2014, to November 28, 2014, were reviewed and revealed six of the ten bath days had either partially completed or absent documentation to indicate whether a bath, hair, or nail care was provided. A PSW reported in an interview that the resident did receive a bath twice a week; however, documentation to endorse that care was incomplete. The ADOC stated that the home's expectation was for staff to complete all documentation which included hair, nail care and the type of bath provided and confirmed that the documentation was incomplete. [s. 30. (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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

A) Resident #18 was admitted to the home in 2015, with an ongoing area of skin breakdown. Review of the plan of care did not include a head to toe skin assessment by a member of the registered staff within 24 hours of admission. Interview with the Wound Care Consultant confirmed that a head to toe assessment was opened in Point Click Care (PCC) but not completed as required and skin breakdown present on admission was not assessed until two days after admission. [s. 50. (2) (a) (i)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all planned menu items were offered at each meal.

Resident #65's plan of care stated they were underweight related to erratic intake at meals. On July 28, 2015, during lunch meal service, the resident was observed eating their main course slowly. A dietary aide removed the main course dish when the resident finished it and began cleaning their table. Nursing staff were observed assisting residents out of the room, including resident #65. The Long Term Care Homes (LTCH) Inspector asked if the resident was offered dessert, and staff confirmed they were not. Staff then offered dessert, which the resident accepted and finished. [s. 71. (4)]

WN #16: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if none, in accordance with prevailing practices.

A) On July 29, August 5 and 6, 2015, a fall mat was observed in resident #20's room, heavily soiled with dried fluid stains and dry debris, as well as notable thick dark orange debris in crevices at the edge of the mat, which was confirmed by a housekeeping staff on August 6, 2015. PSWs reported fall mats were to be cleaned at by PSWs on night shift. Review of the home's PSW Night Cleaning Schedule did not specify if and when PSWs were to clean fall mats and was found incomplete for seven of the 12 days from July 26 to August 6, 2015. The DOC reported fall mats were to be cleaned by PSWs; however, confirmed the cleaning schedule did not state floor mats were to be cleaned and that the cleaning documentation was incomplete.

B) On July 28 and August 12, 2015, a plastic chair was observed in the tub room, heavily soiled with wet thick blue residue and brown rust rings, which could be wiped off. PSWs reported that they were responsible for ensuring the chair was cleaned after each use for infection prevention and control as residents used the chair during aspects of care and confirmed that it was heavily soiled. The ADOC confirmed that the chair was to be cleaned after each use. [s. 87. (2) (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint.

In November 2014, a verbal complaint was made by family to a staff member regarding the care provided to resident #60 in relation to their personal care. The Program Manager confirmed in an interview that they received a complaint from the family and that they reported it to either the Administrator or DOC. The home's complaints log was reviewed and did not contain documentation regarding the complaint. The DOC and Administrator were interviewed and did not recall receiving information regarding the complaint. The Administrator reported that a complaint of such matter would have been logged and investigated. [s. 101. (1) 1.]

2. The licensee failed to ensure that a written record was kept of each quarterly review of complaints received and of the improvements made in response to the analysis.

A review of the home's complaints documentation did not include a written record of a review and analysis of trends in the fourth quarter of 2014. The Administrator reported that complaints were reviewed but there was no written record of the analysis and improvements made in response to the analysis. [s. 101. (3)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD used under section 33 of the Act was applied by staff in accordance with any manufacturer's instructions.

On August 12, 2015, resident #61 was observed in a wheelchair, with a front fastening seat belt applied. The belt appeared to be five finger widths from their torso. The resident was able to release the belt independently when asked. Registered staff confirmed the belt was loose, was not applied in accordance with manufacturer's instructions and proceeded to adjust and apply the belt properly. [s. 111. (2) (b)]

WN #19: 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. (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 all staff who provided direct care to residents received annual training related to falls prevention and management and skin and wound care, as required under subsection 76(7) of the Act.

Review of the education records indicated that direct care staff did not receive annual training related to falls prevention and management and skin and wound care in 2014. This was confirmed by the DOC and ADOC. [s. 221. (2) 1.]

Issued on this 10th day of September, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2015_337581_0014
Log No. / Registre no:	H-002977-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 1, 2015
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE HAMILTON 90 CHEDMAC DRIVE, HAMILTON, ON, L9C-7S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pilar Henderson

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_250511_0029, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan demonstrating how the home will ensure that care set out in the plan of care is provided to resident's #18, #44, #61 and #80.

1) Specifically, the plan shall include actions needed to ensure the above residents are provided with the required assistance for toileting, mobility and application of PASD's; and receive food and fluids at a safe consistency as specified in their plans.

2) The plan will include a process for sustainability to ensure that the home will maintain a long term goal of compliance (i.e should the care needs of the resident change, the plan of care and care needs of the resident are congruent and implemented as such).

3) The plan shall be submitted electronically to Dianne Barsevich, LTC Homes Inspector, Ministry of Heath and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at dianne.barsevich@ontario.ca by the end of business day on September 15, 2015.

Grounds / Motifs :

1. Previously issued as an order in January 20, 2015.

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

A) The plan of care for resident #18 identified that the resident required a table top tray as a PASD, to assist the resident with food and fluid intake. On July 31, 2015, the resident did not have a table top placed on their wheelchair during breakfast service. Interview with the PSW and the RPN confirmed that the table top was to be applied for meals and was not applied as specified in the plan of care. (528)

B) Resident #61 had a plan of care to receive pudding thick fluids, as they had swallowing difficulties related to dysphagia, as evidenced by coughing at meals and received a nutritional supplement.

i) On July 30, 2015, during lunch meal service, resident #61 was observed drinking their nutritional supplement which was not thickened and puree soup, which was nectar consistency. The resident had a wet cough after consuming the fluids and was coughing repeatedly throughout the meal. The dietary aide reported the resident required pudding thick fluids and confirmed they served regular puree soup. The RPN who provided the supplement confirmed the resident required thickened fluids and was not served a thickened nutrition supplement.

ii) On August 5, 2015, during lunch meal service, resident #61 received puree soup and coffee, both prepared to a nectar consistency. The PSW who provided the coffee confirmed the resident required pudding thick fluids. The resident was observed consuming their nutritional supplement, which was thickened but lumpy. The resident had a wet cough after consuming the fluids and was coughing repeatedly throughout the meal service. The FSM confirmed the supplement was lumpy and not prepared and served according to the resident's care needs. The Registered Dietitian stated the resident was to receive pudding thick fluids for all fluids, including soup and fluid supplements and confirmed the care set out in the plan of care was not provided to the resident as specified in the plan. (585)

C) The plan of care for resident #44 identified the resident was frequently incontinent and interventions included but were not limited to extensive assistance of two staff for toileting the resident in the morning, before lunch, before dinner, at bedtime and as needed. On August 11, 2015, the resident was observed from 1530 hours to approximately 1800 hours seated in their wheelchair and incontinent odours were noted. The resident was escorted to

the dining room for dinner at approximately 1645 hours without being toileted. After dinner service, interview with PSW confirmed that the resident was not assisted to the toilet as outline in the plan of care. (528)

D) In February 2015, resident #80 fell and sustained an injury. In December 2014, the Physiotherapist assessment identified the resident was a two person assistance for walking with a rollator walker and the wheelchair behind them. Interview with the PSW who provided care on the day of the fall stated they walked the resident in their room and to the washroom with their rollator walker with one person extensive assistance. The ADOC stated that the PSW's were to follow the written plan of care by the Physiotherapist related to walking the resident and confirmed that the plan of care was not provided to the resident as specified in the plan.
(581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure:

1) That all staff use safe transferring techniques established by the interdisciplinary team, including but not limited to Physiotherapist assessments, when transferring residents.
2) Education for staff on safe transferring techniques used in the home to prevent falls.
3) The development and implementation of a system of ongoing monitoring to ensure staff comply with the process.

Grounds / Motifs :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified day in February 2015, resident #80 was standing with their rollator walker after being toileted with extensive assistance of one staff. According to the progress notes the PSW turned their back to the resident to pick an item up off the floor and the resident fell and was transferred to hospital. Review of the plan of care indicated that the resident was extensive assistance with one person physical assist for all transfers including toilet use. Review of the PSW flow sheets from December 2014, to February 2015, revealed the resident was transferred from bed, chair or standing position with extensive assistance (staff provide weight bearing support) and one person physical assistance. The physiotherapist assessment and written plan of care indicated that the resident was transferred with one person assistance and was walked in the corridor with assistance of two persons and the wheelchair behind. Interview with the PSW who was providing care when the incident occurred stated that the resident was standing with their rollator walker and lost their balance and fell. PSW confirmed they were not providing any physical assistance to the resident when they bent over to pick an item up off the floor and the resident's wheelchair was not in the bathroom at the time of the fall. The ADOC confirmed that the PSW did not provide extensive assistance when transferring the resident at all times and that staff did not use safe transferring when assisting resident #80.

(581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 16, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1) Develop a comprehensive bed safety assessment tool using as a guide the US Federal Food and Drug Administration document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
2) An interdisciplinary assessment of all residents, including but not limited to resident #12 and #17, using the bed safety assessment tool shall be completed and the results and recommendations of the assessment shall be documented.
3) Update all resident health care records to include why bed rails are being used and how many are to be used.
4) Ensure all bed systems are retested for potential zones of entrapment when any changes to the bed system occur and the assessment is documented.
5) Educate all health care staff with respect to when to apply bed rails for each resident, why they are being applied and general bed safety hazards.

Grounds / Motifs :

1. Previously issued as a VPC on January 20, 2015.

The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with

prevailing practices, to minimize the risk to the resident.

The following residents had not been assessed according to prevailing practices adopted by Health Canada in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" developed by the US Food and Drug Administration, which outlined that decisions to use or to discontinue the use of a bed rail would be made in the context of an individualized patient assessment using an interdisciplinary team with input from the patient and family or the patient's legal guardian.

A) The MDS Kardex for resident #12 identified that they required, " bed rails for bed mobility or transfer". On an identified day in August 2015, two three quarter bed rails were removed from the resident's bed and inspector observed two rotating assist rails on the bed in the transfer position. Review of the plan of care did not include an assessment of either bed rails used on their bed. Interview with the resident revealed they preferred one three quarter bed rail on the right side raised when in bed for turning, positioning and safety. Interview with the Environmental Manager confirmed that resident #12's bed rails were changed in August 2015, as they failed potential zones of entrapment. Review of the bed entrapment worksheet indicated that in April 2015, the resident's bed system failed zone two for potential entrapment with the two three quarter bed rails raised on the bed and did not include an assessment for any zones of entrapment for the new assist rails. The ADOC confirmed that there was no formalized assessment completed for resident #12 related to the use of bed rails nor was there an assessment completed for the potential zones of entrapment related to the new rails.

B) On an identified day in August 2015, resident #17's bed rails were changed from two three quarter bed rails to two rotating assist rails. Review of the plan of care revealed the resident used two three quarter bed rails for bed mobility, transfer and for safety as requested by family; however, the plan of care did not include a bed rail assessment for the new assist rails on their bed. Review of the bed entrapment worksheet from April 2015, identified that the resident's bed system failed zone two for entrapment with two three quarter rails raised on the bed and were not retested for potential zones of entrapment when the new rails where installed on the bed. Interview with ADOC and Environmental Manager confirmed there was no formalized assessment completed for resident #17 related to the use of the new bed rails nor was there an assessment completed

for the potential zones of entrapment.

Furthermore, the ADOC confirmed that on an identified day in August, 2015, bed rails where changed or removed on seven resident's beds and no formalized bed rail assessments were completed to determine if bed rails were required or not.

(581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 1st day of September, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dianne Barsevich

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