Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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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
Dec 22, 2016	2016_286547_0032	011460-16	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 LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

LISA KLUKE (547), GILLIAN CHAMBERLIN (593), LINDA HARKINS (126), MELANIE SARRAZIN (592)

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): November 9,10,14,15,16,17,18,21,22,23 and 24, 2016

The following critical incidents and complaint inspections were conducted concurrently during this inspection:

Log #018784-16 related to resident injury with hospitalization and change in

condition
Log #021615-16 related to a resident fall that resulted in fracture
Log #022197-16 related to an alleged resident to resident verbal abuse incident
Log #025845-16 related to an alleged resident to resident physical abuse incident
Log #028127-16 related to a resident fall that resulted with injury
Log #028523-16 related to an alleged staff to resident verbal abuse incident
Log #028637-16 related to a resident fall that resulted with injury
Log #029309-16 was a complaint related to alleged staff to resident abuse
Log #032821-16 related to an alleged resident to resident sexual abuse incident and
Log #033117-16 related to an unexpected death of a resident

During the course of the inspection, the inspector(s) spoke with residents, family members, the Presidents of Resident and Family Councils, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Skin and Wound care champion nurse, an Office Manager, Physiotherapy Assistant (PTA), Food Service attendants, the home's Building Systems Operator, a laundry attendant, the Food Services Supervisor, the Activities Programmer, the home's Geriatric Psychiatry Outreach nurse, the Associate Director of Care (ADOC), the National Director for Infection Prevention and Control for Extendicare, the Regional Director for Extendicare and the Administrator.

The inspectors toured the home and observed resident care being provided, medication administration passes and infection prevention and control practices and several meal services. The inspectors reviewed resident health care records, the resident's mobility equipment cleaning schedule, the home's housekeeping schedule for lingering offensive odors procedures and Pest control procedures, food production documents including planned menus and the resident and family general meeting minutes. The inspectors reviewed documentation related to the home's investigations into the above critical incidents and policies related to the home's skin and wound care and prevention of abuse programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **12 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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 has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

For the purpose of this report, the communication and response system is referred to as a call bell system.

During the initial tour on November 09, 2016, Inspector #592 observed a common area for residents on the ground floor adjacent to the lobby where three residents were watching television and three other residents were engaged in a conversation. Inspector #592 was unable to locate any call bell system in this common area.

In an interview with the Activity Programmer who was present at the time of this observation, she indicated to Inspector #592 that there was no call bell system in this room. She indicated that this room was a common area for residents where a variety of activities occurred daily. She further indicated that in the case of an emergency she would get the management team which are located near the lobby.

On November 15, 2016, in an interview with the Building System Operator, he indicated to Inspector #592 that this room was called the "Trillium Room" which was a common area used by residents. He further indicated that there was no call bell system installed in this room. [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 "Trillium room" will be equipped with a resident-staff communication and response system, to be implemented voluntarily.

WN #2: 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 has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between resident #051 and resident #052 including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and (b) identifying and implementing interventions.

On a specified date in July, 2016, the Ministry of Health and Long Term Care Director received via the Critical Incident Report System an allegation of abuse between resident #051 and resident #052.

Resident #051 and #052 were admitted to the home on different dates approximately three years ago with several medical diagnoses. Resident #052 mobilizes self with an electric wheel chair (W/C). Resident #051 and resident #052 reside on the same floor on opposite end units. They both self ambulate and go downstairs to the back yard on a daily basis.

Resident #051's health care record was reviewed by Inspector #126. The progress notes were reviewed for a specified period in 2016 and several verbal and physical altercations were noted between resident #051 and resident #052. The following incidents were documented:

On a specified date, resident #051 informed an Activity Staff member that he/she felt upset because resident #052, yells, screams, swears, and spits all over the place and still gets treated like a king/queen.

On a specified date one month later around lunch hour, resident #051 became very upset, angry and yelling at resident #052, stating that he/she will hit resident #052 in the face because he/she spit on the resident four times. Resident #052 responded angrily so resident #051 came close with the electric W/C and bumped into resident #052 intentionally, saying he/she was aiming to hurt the resident. Both residents were separated and resident #051 continued shouting and swearing at resident #052. After approximately 20 minutes, resident #051 calmed down but kept saying that he/she would hit resident #052 next time.

On a specified date approximately 20 days later around lunch hour, resident #051 came back to the unit from the main floor via the elevator shouting and swearing, as soon as the elevator door opened resident #051 reached at resident #052 and pulled the resident by the shirt, and started to hit and push the resident against the medication cart. Residents were separated by three staff and the police were called. There was no injury to resident #052. The Police suggested to move one of the residents to another floor. Resident #051 was on a wait list to move to the another floor.

On a specified date approximately a week later in the morning, the Assistant Director of Care (ADOC) observed resident #052 coming from outside through the front door of the home and resident #051 was also on the main level speaking to the Office Manager. As resident #052 was about to go out of the facility, resident #051 blocked the doorway and kept calling resident #052 names and kept swearing at the resident. Resident #051 wouldn't stop yelling and resident #052 just avoided and ignored resident #051. Resident #052 waited until resident #051 went to the backyard to exit the facility.

On this same day before lunch, the Activity Program Manager (APM) heard residents yelling in the backyard and went outside and was told that resident #052 had thrown a brick at resident #051. Resident #051 indicated that the brick hit the resident on the right thigh. Resident #051 was assessed by a nurse and the physician and there was no visible injuries and the resident denied having any pain. The ADOC interviewed resident #052 who explained what had happened and felt threatened by resident #051 and that is why resident #052 threw the brick at resident #051 for self-defence. The surveillance camera footage of the back yard was viewed that same day by the ADOC, the Social Worker (SW) and the Environmental Service Manager. Resident #052 was observed to be wheeling self toward the back tent throwing something in the garbage. Resident #051 was seen going towards resident #52 and hovering around the resident. Resident #051 appeared to be yelling at resident #052 and then resident #052 was seen moving closer

to resident #051 and threw the brick at the resident. Resident #051 tried charging resident #052 with an electric W/C when a housekeeper tried to prevent things from escalating.

The next day after breakfast, resident #051 passed resident #052 in the Trillium Room on the main level and was observed cursing and shouting at resident #052.

Two days after the original incident in the back yard, resident #051 was heard screaming and shouting around lunch time at resident #052. Resident #051 threatened resident #052 multiple times stating that he/she was "going to punch and throw bricks at resident #052". Resident #051 cannot easily be redirected or reoriented. Resident #051was observed waving a fist at resident #052 and staff. One on one sitter was started on this day for a period of seven days to ensure resident #052 is safe.

Three days later, resident #051 was sitting in the backyard in the afternoon with a sitter and was observed shouting, cursing, threatening to kill and punch resident #052. The next morning, resident #051 was waiting for the elevator when resident #052 came to take the elevator to go down and resident #051 started screaming and yelling profanities and threatening resident #052. Resident #051 continued to chase after resident #052 with an electric wheelchair. The sitter was unable to calm or control resident #051. Later that same day resident #051 was on the main floor, yelling and threatening to kill resident #052. Resident #052 went in the office for security. Resident #051 was so aggravated that he/she ran over the receptionist foot with the electric wheelchair. Physician was notified and resident #051 was transferred to the hospital. Resident #051 returned to the home that same evening.

One week later in the morning, resident #051 was overheard shouting and cursing at resident #052 in the lobby area and indicated wanting to throw a chair at resident #052. Resident #051 followed resident #052 outside. Later that day, in the Trillium Room, resident #051 was threatening resident #052 that he/she would "bash resident #052's brains in." Two days later in the morning, resident #051 got angry when he/she saw resident #052. Resident #051 started to call resident #052 names and was using an electric wheelchair at a fast pace heading toward resident #052. Staff in the lobby had to stop resident #051 from wanting to hurt resident #052. The physician was notified and resident #051 was transferred to the hospital.

Resident #051's plan of care did not include any factors, potential trigger such as resident #052 and the responsive behaviours of resident #051 in the presence of resident

#052. Resident #051 was exhibiting escalating responsive behaviours in the last few months specifically toward resident #052.

On November 24, 2016, Inspector #126 interviewed resident #052 who indicated not being afraid of resident #051 because they were just threats. Resident #052 never received any injuries from all these incidents and that now everything was better because resident #051 no longer resided in the home.

On November 24, 2016, Inspector #126 interviewed the ADOC who indicated that some interventions were implemented to ensure resident #051 was on wait list for another facility and the Psychogeriatric Team was involved. The ADOC indicated that the home was aware of the potential harmful interactions between both residents however, the behavioural triggers for the resident were not identified and strategies were not developed and implemented to respond to these behaviours.

No documentation was found related to the strategies of managing the trigger and responsive behaviours of resident #051. [s. 53. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that registered nursing staff identify triggers for responsive behaviours and implement strategies to ensure safety of other residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle, included alternative beverage choices at snacks.

For the purposes of this report, the snack is referred to as the nourishment pass.

During the afternoon nourishment pass on a specified floor in the home on November 15, 2016, Inspector #593 observed a PSW offering beverages and snacks to residents in this area. It was observed that there was only one variety of thickened fluid available on the cart, which was thickened apple juice. There was no alternative choice for residents requiring thickened fluids during this afternoon nourishment pass. During the morning nourishment pass on this same floor on November 17, 2016, at 1010 hours Inspector #593 observed PSW #113 serving apple juice to residents seated in the dining room. There were no other beverage choice available for residents during this nourishment pass.

A review of this floor's diet roster by Inspector #593 on November 15, 2016, found that four residents in this home area required thickened fluids.

During the morning nourishment pass on another specified floor on November 17, 2016, Inspector #126 observed a PSW offering apple juice to residents in this home area. There was no other beverage choice available or being offered to residents during this morning nourishment pass.

During an interview with Inspector #126 on November 17, 2016, PSW #115 reported that the kitchen prepare the cart, and apple juice was the only beverage available on the cart

that morning.

During an interview with Inspector #593 on November 18, 2016, the Dietary Manager reported that they only include one option of beverage on the posted menu for the between meal nourishment and the staff are following this.

A review of the posted Fall / Winter menu for 2016 – 2017 found that one beverage option was documented at each AM, PM and HS snack however an additional statement was documented which read: coffee, tea, water and milk offered at each meal and nourishment. [s. 71. (1) (d)]

2. The licensee has failed to ensure that each resident was offered a minimum of a between meal beverage in the morning.

On November 9 and 10, 2016 resident's #005 and #008 who both reside on the same floor, reported to Inspector #593 that they were not offered fluids in between meals.

Observations by Inspector #593 on November 16, 2016, found that no morning nourishment pass was completed on this specified floor.

During the morning nourishment pass on this specified floor on November 17, 2016, at 1010 hours, Inspector #593 observed PSW #113 serving apple juice to residents seated in the dining room. There were no thickened fluids observed being served to any residents requiring thickened fluids. After the residents were served, the PSW was observed at 1028 hours to take the cart with the remaining apple juice back to the kitchen. Inspector #593 observed 32 other residents in their rooms or the corridor of the unit that were not offered a beverage during this morning nourishment pass.

During the morning nourishment pass on another specified floor on November 17, 2016, Inspector #126 observed a PSW offering regular apple juice to residents in this home area. There was no beverage available for residents requiring thickened fluids during the nourishment pass.

During an interview with Inspector #126 on November 17, 2016, PSW #115 reported that the kitchen prepare the cart, and regular apple juice was the only beverage available on the cart that morning. PSW #115 added that thickened fluids were available in the fridge however they were not observed to be serving any to residents that morning.

A review of this specified floor diet roster by Inspector #593 on November 18, 2016, found that five residents in this home area required thickened fluids.

Observations by Inspectors #592 and #547 on November 17, 2016 found that no morning nourishment pass was completed on the remaining two floors in the home.

During an interview with Inspector #593 on November 18, 2016, the Dietary Manager reported that the kitchen was responsible for preparing the nourishment carts and then delivering them to each floor of the home. The Dietary Manager added that it was the responsibility of the PSWs on each floor to distribute the mid-meal nourishment. [s. 71. (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 each resident is offered a minimum of a between meal beverage in the morning and that a variety of fluids be available to each resident in required textures at nourishment passes, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #030 related to bowel management.

On a specified date, resident #030 was admitted to the hospital related to a bowel condition and returned to the home one week later.

On November 18, 2016, Inspector #126 had a discussion with Registered Practical Nurse (RPN) #104, who indicated that if a resident does present with actual specified bowel condition, the resident medical directives should be followed and a specific plan of care shall be developed as per the Bowel Management Program. RPN #104 indicated that bowel management is monitored by the night staff and then the medical directives are implemented.

Resident #030's current care plan was reviewed and no documentation was found related to potential risks of this bowel condition. Resident #030's flow sheets were reviewed and it was noted that upon the return of the resident from hospitalization, the daily monitoring of the bowel movements were not documented on a daily basis for a five day period after the resident's return from hospital.

On November 18, 2016, Inspector #126 interviewed Personal Support(PSW) #110 who indicated that she was not aware that resident #030 had a specified bowel condition recently and was not aware that close monitoring of the bowel movements was important.

The plan of care was not updated related to bowel management to give clear directions to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #045 as specified in the plan.

Resident #045 was a resident in the home for several years. Resident #045 was diagnosed with cardiac and respiratory diseases. Resident #045 died in the home on a specified date.

On November 23, 2016 RN #135 indicated to Inspector #547 that she was the registered nursing staff in the home when resident #045 died. RN #135 indicated that she was

called by RPN #136 at a specified time as resident #045 was unresponsive. When RN #135 arrived to the unit, resident #045 was being transported to the resident's room and she followed. RN #135 indicated that she did not stop to check the resident's advanced directives information the home keeps in the resident's manual chart. RN #135 indicated that the home's expectations for residents that require Cardiopulmonary Resuscitation (CPR), to begin immediately if they are not aware of the resident's advanced directives and to delegate a staff member to verify the resident's chart. RN #135 indicated that she performed CPR until the paramedics arrived on the unit. The paramedics continued CPR and RN #135 was then able to go back to the resident's chart and verify the resident's plan of care as level 2-Do Not Resuscitate (DNR). RN #135 then informed the paramedics after 20 minutes of CPR on the resident and resuscitation attempts were stopped. RN #135 indicated that the paramedics pronounced the resident's death at a specified time.

On November 23, 2016 Inspector #547 interviewed RPN #136 who was working the day when resident #045 died. RPN #136 indicated that she recalled PSW #132 calling out for assistance as resident #045 was unresponsive. She had her hands full of medications as in the middle of afternoon medication pass and she asked PSW #137 and RPN #138 to respond. RPN #136 then went to page the charge RN and then called the resident's physician. RPN #136 indicated that she did not verify advanced directives for this resident at this time.

The resident's Do Not Resuscitate (DNR) status is identified on the resident's care plan as well as in the resident's manual chart on an advanced directives consent form signed originally by the resident. The ADOC indicated to Inspector #547 that these decisions are very important to residents and this decision is reviewed annually at the resident's care conferences and that the resident's plan of care for advanced directives was not respected. [s. 6. (7)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that verbal abuse of resident #031 by a staff member that resulted in harm, immediately report the suspicion and the information upon which it was based to the Director.

Verbal abuse is defined as per O.Reg. 79/10,s.2(1) as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On November 10,2016 resident #031 reported to Inspector #547 of an alleged incident of staff to resident abuse that occurred on a specified date. Resident #031 reported to the home's ADOC on this same date that PSW #106 was rude and demeaning towards the resident when the resident asked for assistance. The resident indicated that PSW #106 shoved the resident by pushing the resident's arm and shoulder stating " what do you want me to do about it", and then walked away from the resident. Resident #031 indicated to the ADOC, to have found this to be abusive actions towards the resident and that it was upsetting.

On November 21, 2016 the ADOC indicated to Inspector #547 that she recalled this incident and that she had reported it immediately to the DOC and the home's Administrator that were working at the time.

On November 22, 2016 the current Administrator indicated to Inspector #547 that upon review of the documentation of this incident on this specified date, that the home had not submitted any critical incident related to alleged staff to resident abuse of resident #031.

It is noted that the home was issued an order CO #001 inspection #2016_290551_0008 related to duty to protect in June 2016 and this order was complied in October 2016. This incident occurred prior to this order and improvements in the home's processes regarding reporting abuse, immediate investigation and providing investigation results have been noted. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #010 was based on, interdisciplinary assessment of dental and oral status, including oral hygiene.

During an interview with Inspector #593 on November 15, 2016 with PSW #113, resident #010's regular PSW on day shift, reported that resident #010 required physical set up and cueing for oral and dental care. PSW #113 added that the staff need to take the resident to the bathroom and physically provide the tools for oral and dental care and then the resident is able to clean his/her own teeth however would not be able to do this without physical assistance and cueing.

During an interview with Inspector #593 on November 17, 2016 with PSW #122, resident #010's regular PSW on evening shift, reported that resident #010 required physical set up and cueing for oral and dental care. PSW #122 further reported that when the resident finishes this task, the resident will use the call bell and the PSW will assist in finishing up.

A review of resident #010's plan of care found no documentation related to oral or dental care, or the specific set-up and cueing required for this daily care to be completed.

During an interview with Inspector #593 on November 18, 2016, the ADOC reported that the care plan for all residents' should have a specific focus for oral and dental hygiene which has been individualized for each resident by a member of the registered nursing staff for each home area. [s. 26. (3) 12.]

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 has failed to ensure that when a resident exhibited altered skin integrity, including a skin tear received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument.

On a specified date resident #019 was observed by Inspector #126 to be up and about inside the resident's room. A dry dressing was observed on a specified area on the resident and was noted to have small scant amount of brownish discharge. Resident #019's health care record was reviewed and no assessment of the skin tear or dressing change was documented between specified periods. In a progress note on a specified date, resident #019 was found sitting on the floor which resulted in a superficial skin tear on a specified area. It is documented that resident #019 had a skin tear, but no description, treatment or plan for the tear was documented.

On a specified date, a discussion was held with the Wound Care Nurse Champion, Registered Practical Nurse (RPN) #104, who indicated to Inspector #126 that when a resident presents a skin tear, the registered nursing staff should complete a "Skin - Weekly Impaired Skin Integrity Assessment"(WISIA) and document the wound information in the Treatment Assessment Record (TAR) for dressing change. RPN #104 indicated that she had seen a dressing on the resident, but did not know the reason the resident had a dressing.

On a specified date, dressing on the resident's skin tear was changed and assessed by RPN #104. The tear was assessed as being a specified dimension, with a dry scab and no infection observed. The WISIA and the TAR was initiated and a note was documented in the resident's progress notes.

On a specified date Inspector #126 held an interview with resident #019 related to the skin tear and the resident was not able recall who applied the dressing.

Between two specified dates, a discussion was held with Registered Nurse (RN) #019 and four RPN's, and none of them had applied a dressing on the skin tear or completed a WISIA or documented in TAR and the progress notes. [s. 50. (2) (b) (i)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond within 10 days of receiving Family Council advice related to concerns or recommendations.

On November 22, 2016 a member of the Family Council indicated to Inspector #547 that the home usually respond to concerns raised at the Family Council Meetings at the next meeting.

Upon review of the Family Council minutes for October and November 2016, issues were identified to the home via the Assistant to Family Council, however responses to the Family Council were not documented for either of these meetings.

On November 22, 2016 the Administrator indicated to Inspector #547 that the home has not been providing responses to the Family Council concerns within the 10 days as required by this section but she planned to work on a solution for this area with the Assistant to the Family Council. [s. 60. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that required information is posted in the home, in a conspicuous and easily accessible manner that complies with the requirements.

During the initial home tour on November 9, 2016, Inspector #593 was not able to locate several required postings in the home. This included the home's procedure for initiating complaints to the licensee, a copy of the service accountability agreement entered into between the licensee and the local health integration network and copies of the inspection reports from the past two years for the long-term care home.

During an interview with Inspector #593 on November 9, 2016, the Regional Director for Extendicare indicated that the above mentioned required postings were not posted in the home as required.

During an interview with Inspector #593 on November 17, 2016, the Administrator also indicated that multiple required postings were not posted and reported that these were being removed by residents and/or visitors of the home. To ensure that all required postings were available in the home, the Administrator reported that the home had just recently implemented a process for the Office Manager to make sure that all postings were checked weekly and replaced if necessary so that they were always available in the home. [s. 79. (1)]

WN #10: 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 has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors.

On November 09, 2016 at 1145 hours and 1510 hours, lingering offensive odors were

identified by Inspector #547 in a specified room and shared bathroom.

On November 15, 2016 at 1030 hours, lingering offensive odors was identified by Inspector #592 in another specified room and shared bathroom.

Housekeeping attendant #105 indicated to Inspector #592 during an interview that each resident's floor and washrooms were washed on a daily basis. She further indicated that once a day a resident's room was assigned for a deep cleaning. Housekeeping attendant #105 indicated to Inspector #592 that she was using a product to eliminate odors and showed the Inspector a spray bottle titled "odor eliminator". The Housekeeping attendant #105 further indicated that the instructions received from the Building Systems Operator during an education session, were to use the product as needed whenever offensive odors were present throughout their shift. She further indicated that no specific rooms were identified with lingering odors on this unit.

Housekeeping attendant #105 accompanied Inspector #592 to room this specified room and indicated to Inspector #592 that there was an offensive lingering odor present in the resident's room and in the shared bathroom. She further indicated that she was also receiving complaints from a resident residing in the next room who is using this same shared bathroom for these rooms. She further indicated to Inspector #592 that the home was aware and that they were unable to determine the source. She further indicated to Inspector #592 that no specific instructions were received for the identified room, therefore cleaned this specified room the same as the other rooms.

On November 15, 2016, resident #042 indicated to Inspector #592 that the odor in the shared bathroom was offensive. Resident #042 indicated to have asked staff to clean the bathroom in order to manage the odor however the odor remained. Resident #042 requested to use the visitors and staff washroom due to the odor in this specified washroom but the resident was instructed to use the resident's own bathroom. Resident #042 indicated to Inspector #592 that he/she would need a mask at times to manage the odors in this shared bathroom.

On November 16, 2016, in an interview with PSW #102, she indicated to Inspector #592 that she was aware that there was presence of offensive lingering odor daily in this specified room and that it was a challenge for staff members to get rid of the odor. PSW #102 further told Inspector #592 that the staff are cleaning the room often but that the lingering offensive odors still persist.

On November 15, 2016 the Building System Operator indicated to Inspector #592 that there was a process in place to manage offensive lingering odors by having small air units on each resident unit. He further indicated to Inspector #592 that a new product has been in trial several weeks ago to neutralized lingering odors. He showed to the Inspector a plastic container labelled " Bio-Enzymatic odor Eliminator Waterfall mist". He further indicated to Inspector #592 that the product was first tried on the third floor where lingering odors were identified and was pleased of the results. He further indicated that there was no specific room identified with lingering odors and that the product was only to be used when odors were present or noted by housekeeping staff.

The Building System Operator further indicated to Inspector #592 that he was aware that this specified room was a challenge and that one of the residents who was residing in this room was hoarding stuff which the home and the resident's family had done a big clean-up of the room but that the lingering odor was still re-occurring. He told Inspector #592 that following the re-occurrence of the odor that he had asked one housekeeping attendant to use the "odor eliminator" spray on a daily basis when cleaning the room. He further indicated that he had forgotten to communicate the instructions to the other Housekeeping attendants in the home, therefore the process to eliminate lingering odors in this specified room was not implemented. [s. 87. (2) (d)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On November 14, 2016, during an observation of medication administration, RPN #100 indicated to Inspector #592 that resident #029 and #041 were self-administering specified prescribed drugs and were keeping them at their bed side.

On November 14, 2016, resident #029 and #041 confirmed with Inspector #592 that they were self-administering these specified prescribed drugs.

A review of resident #029 and #041's health care records by Inspector #592 revealed documentation from the physician for the use of the specified drugs for both residents. No orders were found for the self-administration for both these residents.

During an interview with RPN #100, she indicated to Inspector #592 that she was not able to find any documentation from the prescriber for the approval of self-administration for both residents.

During an interview, the Director of Care indicated to Inspector #592 that any resident who self- administer medication, should have an evaluation completed for their ability to self-administer and has to be approved by the prescriber. [s. 131. (5)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that personal support workers (PSW) participate in the implementation of the infection prevention and control program regarding personal care items not properly stored in shared resident bathrooms.

The Inspection team made the following observations of personal care items not properly stored during this inspection:

On November 9, 2016 Inspector #592 observed two specified rooms to contain the following:
- a specified bathroom had a soiled single use urine container on top of a toilet seat stored on the floor
- another specified shared bathroom had a soiled single use urine container hanging on a resident grab bar

On November 10, 2016 Inspector #126 observed four specified bathrooms to contain the following:
- a specified bathroom had a used single use urine container stored on the floor
- a specified shared bathroom had a plastic commode seat, a used single use urine container and a used green urinal stored under the sink
- another specified shared bathroom had a used single use urine container stored on the floor and this was observed again on November 17, 2016 by Inspector #547
- another specified shared bathroom had two used single use urine containers stored under the bathroom sink

On November 17, 2016 Inspector #547 observed the following:
- a specified shared bathroom had a soiled single use urine container
- another specified shared bathroom had two unlabelled used blue denture cups located inside a single use urine container that had dust and dried matter inside it, piled into a blue wash basin
- another specified shared bathroom had two used single use urine containers and a used blue wash basin
- another specified shared bathroom had a used single use urine container located inside a used blue wash basin
- another specified shared bathroom had two used single use urine containers located inside a used wet blue wash basin on the floor under the sink
- a specified bathroom had two denture cups located on the back of the toilet, one was right side up, with no cap that had dried white matter inside it and the other was upside down on the top of the toilet tank. Two used blue wash basins were stored on a shelf near the floor

On November 17, 2016 RPN #101 indicated to Inspector #547 that white urine collectors are to be labelled with the resident's name and stored in the resident bathrooms on the

little shelves provided. Denture cups and wash basins are never suppose to be stored in the bathrooms as they are suppose to be stored in each resident side table. RPN #101 indicated that they have several of these urine collectors for obtaining urine specimens in the clean utility rooms.

On November 17, 2016 PSW #127 indicated that after they have collected a urine specimen for a resident, that they use the soap in the bathroom soap dispenser to wash out the white urine collector container, and then go to the hand sanitizer station to apply some hand sanitizer product to the inside of the white urine collectors to sanitize them and store them in the residents bathrooms for the next time a urine specimen is required. Denture cups or wash basins are not suppose to be in bathrooms as they are to be stored in resident bedside tables.

On November 17, 2016 PSW #124 and #125 reported to Inspector #547 that white urine collectors are provided to them by the registered nursing staff for residents that require a urine specimen. Once the PSW's obtain the urine specimen for the resident, they are to discard the white urine collector in the dirty utility rooms. PSW #124 further indicated that they are not suppose to store white urine collectors after they have been used in the resident's bathrooms.

On November 18, 2016 the National Director for infection prevention and control (IPAC) with Extendicare indicated to Inspector #547 during an interview that these single use urine collectors are utilized for urine specimen collection and should only be used once and then discarded, as they are not designed to be disinfected. The National Director for IPAC with Extendicare further indicated that resident denture cups and wash basins should not be stored in resident bathrooms. [s. 229. (4)]

Issued on this 3rd day of January, 2017

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

Original report signed by the inspector.