Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2016;	2015_247508_0014 (A1)	H-003010-15	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 ST. CATHARINES
283 Pelham Road St. Catharines ON L2S 1X7

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

ROSEANNE WESTERN (508) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The following compliance order dates have been extended from January 29, 2016 to March 1, 2016 as requested by the home.

There have been no changes to any of these orders other than the compliance dates.

Issued on this 20 day of January 2016 (A1)

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

Original report signed by the inspector.

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

ROSEANNE WESTERN (508) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 18, 19, 20, 21, 24, 25, 26, 27, 28, 31, 2015

Please Note: The following inspections were conducted simultaneously with this RQI: follow-ups H-000099-14 related to s. 24(1), H-002063-15 related to s.3(1), H-002062-15 related to s.19(1), H-002064-15 related to r.55, H-003136-15, complaint inspections H-002486-15, H-001341-14, H-002036-15, H-002264-15, Critical Incidents H-002784-15, H-000023-13, H-003135-15, H-003005-15

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Resident Assessment Instrument (RAI) Coordinator, Registered Dietician (RD), Dietary Manager, Program Manager, Quality Risk Management Coordinator , Wound Care Nurse, registered staff, Personal Support Workers (PSW), residents and family members

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Dignity, Choice and Privacy

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

- **13 WN(s)**
- **8 VPC(s)**
- **6 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #001	2014_191107_0022	508
LTCHA, 2007 s. 24. (1)	CO #001	2013_250511_0007	129
LTCHA, 2007 s. 3. (1)	CO #002	2014_191107_0022	508

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #106 exhibited responsive behaviours that included wandering, resistiveness to care and inappropriate behaviours towards co-residents and visitors.

A review of the resident's plan of care indicated that the interventions developed to manage the resident's inappropriate behaviours did not include interventions to minimize risk of harm or altercations towards other residents, only visitors.

It was confirmed during an interview with the RAI Co-ordinator on August 28, 2015, that the resident had a history of being inappropriate towards co-residents and that interventions had not been developed or implemented to minimize the risk of harm or altercations and potentially harmful interactions between and among residents. [s. 55. (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A) A review of resident #104's clinical record indicated that they were admitted to the hospital on an identified date in 2015. A review of the resident's progress notes indicated that the resident returned back to the home and received oxygen therapy via nasal cannula at the rate of three litres per minute.

A review of the home's policy titled, Oxygen (04-06-01 with a revision date of September 2010) indicated the following:

i) Oxygen will be administered to residents in a safe manner where there is a Physician or Nurse Practitioner's order or in emergency situations pending a Physician/Nurse Practitioner's order.

ii) Under Documentation, the care plan is to list oxygen therapy (flow rate, method and

duration) under Special Orders/Monitoring and list measures to be taken to provide specific safety measures, client related personal care or teaching.

A review of the resident's Best Possible Medication History Reconciliation/Admission Orders that were completed as well as a review of the resident's Electronic Medication Assessment Record (EMAR) indicated that no orders had been obtained by the physician or the Nurse Practitioner for the administration of oxygen. A review of the resident's written care plan indicated that no documentation for oxygen therapy including the flow rate, method, duration, specific safety measures or related personal care or teaching had been documented and the care plan did not contain a focus for Special Orders/Monitoring. An interview with the RAI Coordinator confirmed that no orders had been obtained for the resident's oxygen therapy; the care plan had not contained documentation relative to the oxygen therapy provided and that the home had not complied with their policy. (214)

B) A review of resident's #114's progress notes indicated that the resident began demonstrating symptoms of an infection and required oxygen. The resident's progress notes also indicated that they received oxygen therapy via nasal cannula at a specified rate on several occasions.

A review of the home's policy titled, Oxygen (04-06-01 with a revision date of September 2010) indicated the following:

i) Oxygen will be administered to residents in a safe manner where there is a Physician or Nurse Practitioner's order or in emergency situations pending a Physician/Nurse Practitioner's order.

ii) Under Documentation, the care plan is to list oxygen therapy (flow rate, method and duration) under Special Orders/Monitoring and list measures to be taken to provide specific safety measures, client related personal care or teaching.

A review of the resident's Electronic Medication Assessment Record (EMAR) indicated that no orders had been obtained by the physician or the Nurse Practitioner for the administration of oxygen. A review of the resident's written care plan indicated that no documentation for oxygen therapy including the flow rate, method, duration, specific safety measures or related personal care or teaching had been documented and the care plan did not contain a focus for Special Orders/Monitoring. An interview with the Quality Risk Management Coordinator confirmed that no orders had been obtained for the resident's oxygen therapy; the care plan did not contain

documentation relative to the oxygen therapy provided and that the home had not complied with their policy. (214)

C) Staff did not comply with directions contained in the home's "Oxygen" policy identified as # 04-06-01 and dated September 2010, in relation to the following:
i) This policy directed that "Oxygen will be administered to residents in a safe manner where there is a Physician or Nurse Practitioner's order".
- Staff did not comply with this direction when they administered oxygen to resident #102 without an order for oxygen to be administered. Staff and clinical documentation confirmed that the resident received oxygen on a continuous basis at a specified rate on six occasions in 2015 without a physician or nurse practitioner's order.
ii) This policy directed that staff where to document in the care plan "a list of oxygen therapy (flow rate, method and duration) and list measures to be taken to provide specific safety measures, client related personal care or teaching". Staff and clinical documentation confirmed that this direction was not complied with for resident #102. Staff administered oxygen to this resident in 2015 and the resident's care plan did not contain any indication the resident was receiving oxygen on a continuous basis or identified any safety measures that were to be put in place related to the use of oxygen therapy.

D) Resident #110 was identified as a high risk of falls in 2014 and continued to have falls in early 2015. On an identified date in 2015, resident #110 was transferred to hospital and was hospitalized. The resident was re-admitted to the home and had been identified as having a significant change in status due to the resident's decline.

A review of the home's policy titled, Falls Prevention and Management Program (10-02-01), dated April, 2013, directs the staff to complete a Morse Fall risk assessment within 24 hours upon admission for all residents. Ongoing, complete a Morse Fall assessment for a resident at the time of significant change in resident status.

A review of the resident's clinical record indicated that the resident had a significant change in status, however, a Morse Fall risk assessment had not been conducted. The resident had another fall after being re-admitted to the home.

It was confirmed by the RAI Co-ordinator during an interview on August 28, 2015, that the Falls Prevention and Management Program had not been complied with.

E) Resident #200 had a fall on an identified date in 2014, and a post fall assessment was completed by staff that same day. A review of the resident's clinical record

indicated that after the post fall assessment had been completed and documented, the resident was not reassessed for injuries or changes in condition related to their fall.

A review of the home's policy titled, Falls Prevention and Management Program (10-02-01), dated April, 2013, directs registered staff to complete an ongoing assessment of the resident for a minimum of 72 hours after a fall. Each shift the resident is to be assessed for pain, bruising, change in functional status, change in cognitive status and changes in range of motion. All assessments and actions during the 72 hour post fall follow-up are to be documented in the progress notes.

There were no further assessments conducted or documented after the initial post fall assessment was completed.

It was confirmed by the RAI Co-ordinator during an interview on August 28, 2015, that staff did not comply with the home's Falls Prevention and Management Program when the resident had not been reassessed each shift within the 72 hours post fall.

(PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent complaint Log # H-002486-15)

F) Resident #200 had several falls in the home which resulted in the resident sustaining an injury. The resident's family member had called the home with concerns related to the circumstances of the resident's fall.

A review of the home's Complaints policy, dated June 2010, indicated that for verbal complaints not resolved within 24 hours, a written record of the complaint as well as the investigation and the outcome will be retained by the home.

The home's 2015 complaint log contained some documentation around this family member's concern; however, there was not a written record of the investigation of the incident or the outcome.

It was confirmed by the Administrator on August 25, 2015, that the written record of the complaint in the 2015 complaint log did not contain the investigation or the outcome of the complaint.

(PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent complaint Log # H-002486-15)

G) Staff did not comply with the directions contained in the "Palliative Care and Death" policy identified as #RESI-04-04-04 and dated December 2002. Directions contained in this policy indicated that "a written order is required, from discussions of advanced directive, by the attending physician to provide palliative care in the facility".
- Staff and clinical documentation confirmed that this direction was not complied with, when an MDS review completed for resident #105 in early 2015 indicated that the stability of the resident's condition at the time was "End stage disease". The staff person making this documentation confirmed that there was not a physician order in either the computerized record or the hand written record to indicate that resident #105's care focus had changed and was now identified as palliative care.

H) Staff did not comply with the home's policy "Food and Fluid Intake monitoring" identified as RESI-05-02-05 and dated September 2014. This policy directed that "if a resident consumes less than their minimum fluid target levels for three consecutive days, the resident requires a hydration assessment and the hydration assessment must be documented".
- Staff and clinical documentation confirmed that this direction was not complied when clinical records indicated that resident #102 had not consumed their minimum fluid target levels for 31 days on an identified date in 2015 and 30 days a month later in 2015 and a hydration assessment was not completed.
- Staff and clinical documentation confirmed that this direction was not complied with when clinical records indicate that resident #105 had not consumed their minimum fluid target levels on three occasions in 2014 and eight occasions in early 2015 and hydration assessments were not completed during these periods of time.

I) Staff did not comply with the home's policy "Mechanical Lifts" identified as #01-02 and revised on May 2009. This policy directed that residents are assessed with any change in condition and each assessment includes an evaluation of the assistance required to transfer safely from one surface to another.
- Staff and clinical documentation confirmed that this direction was not followed when on an identified date in 2015 the plan of care indicated that resident #300's method of transfer was changed. The resident was now being transferred with the use of a total mechanical lift when previously the resident was being transferred with a sit-to-stand lift. Restorative care staff who made this change to the plan of care confirmed that there was not a documented assessment of the resident. -Staff did not comply with the home's policy "Bed Entrapment and Proper Use of Bed rail Devices", identified as # 08-10-01 and dated April 2011. This policy directed that a reassessment of the resident is to be completed as needs change or with any significant change in

condition.
- Staff and clinical documentation confirmed that this direction was not followed when upon return from hospital in 2015, two quarter bed rails were affixed to resident #300's bed in the absence of an assessment of the resident's needs. Registered staff confirmed that there is not a documented assessment of the resident to determine the appropriate bed system for this resident. [s. 8. (1)]

2. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act.

A review of the home's skin and wound care program policies, specifically the policies titled, Skin Treatments (03-05 and dated June 2010) and Pressure Ulcers (03-07 and dated June 2010) did not include the requirement listed in the Ontario Regulation 79/10, which indicates that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home. An interview conducted with the Director of Care and the home's wound care nurse confirmed that the home's policies were not in compliance with the applicable requirements under the Act. (214) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 had failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Resident #200 had been identified as a high risk for falls and had three falls within a six month period. The resident sustained an injury after the third fall in 2015. Post fall assessments conducted after each of these falls identified that the resident had fallen due to tripping on their clothing.

After the resident's second fall, the home had the resident's clothing altered to minimize the risk of falling again but not all of the resident's clothing had been collected for alterations. Clothing that had not been altered remained in the resident's room. On an identified date in 2015, a staff member assisted the resident with dressing and put on clothing that had not been altered for safety. Later that day the resident tripped which resulted in the resident sustaining an injury.

A review of the resident's plan of care that staff refer to for direction in providing care to residents, did not indicated that staff were to ensure the resident was wearing proper fitting clothes to minimize the risk of falling. The only intervention under the falls focus was to ensure a safe environment.

It was confirmed by the RAI-Co-ordinator on August 28, 2015, that the written plan of care for resident #200 did not set out clear directions to staff and others who provided direct care to the resident.

(PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent complaint Log # H-002486-15) [s. 6. (1) (c)]

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 that resident.

A) A review of resident #104's Minimum Data Set (MDS) coding for section C.-Communication/Hearing Patterns that was completed in May, 2015, indicated that the resident was usually understood and demonstrated clear speech. A review of the resident's written plan of care in place during this time period indicated under the communication focus that the resident sometimes understood; had unclear speech and that their speech was difficult to understand. An interview with the RAI Coordinator confirmed that the MDS coding that was completed in May, 2015, was current and that the plan of care was not based on assessment of the resident and

Quality Risk Management Coordinator confirmed that the resident's plan of care
not based on an assessment of their needs. [s. 6. (2)]

3. The licensee did not ensure that staff and others involved in the different aspe
care of the resident collaborate with each other in the assessment of the resident
that their assessments are integrated and are consistent with and complement ea
other, in relation to the following: [6(4)(a)]

Nursing, Physiotherapy and Restorative Care staff did not collaborate in the assessment of resident #300 upon the resident's return from hospital following surgical repair of an injury on an identified date in 2015. Upon return from hospita nursing staff assessed the resident and identified a care focus related to acute pa Physiotherapy staff assessed the resident and identified a plan of care related to exercises to prevent complications following the injury and restorative care staff assessed the resident and developed a plan of care to increase strength and ran motion in the affected area. Staff in the three disciplines confirmed that they completed individual assessments and did not collaborate with each other so the assessments were integrated and complemented each other in order to meet the identified needs of the resident.

(PLEASE NOTE: The above noted non-compliance was identified while conducti
concurrent Critical Incident Inspection Log # H-002784-15) [s. 6. (4) (a)]

4. The licensee has failed to ensure that the resident's substitute decision-maker (SDM) were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #201 had cognitive impairment and had appointed two family members substitute decision makers (SDM) to make decisions for the resident related to th resident's care and finances.

The resident was admitted to the home in 2009. Four months after the resident was admitted to the home, the resident was ordered a medication to manage the resident's responsive behaviours. The medication dosage had been adjusted twice over a two year period.

Three years later, the resident was ordered an additional medication due to an increase in the resident's responsive behaviours. During the resident's annual care conferences that were held with the SDM's, the resident's medications had been reviewed; however, the SDM's did not have knowledge of what these medications were and what they were being used for.

After the resident's death in 2014, the SDM's requested copies of the resident's clinical record which included the medication administration record (MAR). The SDM's discovered at this time that the medications that had been ordered after the resident's admission were medications to manage the resident's responsive behaviours and their consent had not been obtained.

A review of the resident's clinical record indicated that the SDM's were not notified when the Physician ordered these medications and consent had not been obtained to administer these medications to resident #201.

An interview with the Director of Care on August 27, 2015, confirmed that the resident's SDM's were not given an opportunity to participate in the resident's plan of care when the resident was ordered medications to manage their responsive behaviours.

(PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent Critical Incident Inspection Log # H-002036-15) [s. 6. (5)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, in relation to the following:

A) Resident #106 had responsive behaviours that included inappropriate behaviours towards co-residents and visitors. The resident's plan of care indicated that all staff, in all departments were to closely monitor the resident whereabouts and behaviours when certain identified visitors were present in the building.

It was observed by the LTC Inspector, during this inspection, that these identified visitors were in the home for an activity on the unit where resident #106 resided.

These visitors had been on or near the unit greater than 15 minutes during this observation. Two staff members working on the unit near the visitors were asked by the LTC Inspector if they knew where resident #106 was. The staff responded that they did know where the resident was and then asked the LTC Inspector if the resident was in their room. There were no other staff members visible on the unit during this time.

The LTC Inspector approached the resident's room and observed the resident standing alone in their room. There were no staff observed in the hallway or near the resident's room. The LTC Inspector then immediately notified the DOC that the resident was not being monitored during the time that the visitors were in the building and that staff were not aware of the resident's whereabouts during this time.

It was confirmed by the DOC on August 26, 2015, that resident #106 should have been closely monitored by staff during the time the visitors were in the building.

B) Staff and clinical documentation confirmed that the care set out in resident #300's plan of care was not provided as specified in 2015, when staff used a mechanical lift that had not been approved for use by the resident based on the resident's changing needs. Staff and the clinical record confirmed that on an identified date in 2015, restorative care staff identified that the resident's ability to stand and bear weight had deteriorated, that the sit-to-stand mechanical lift was no longer safe for the resident to use and the plan of care was changed to indicate that a total mechanical lift with full sling was to be used for all transfers of the resident. A registered staff member who was asked to assess the resident following the attempt to transfer the resident due to a high level of pain the resident experienced, confirmed that staff had used the incorrect mechanical lift. During interviews conducted by the home two Personal Support Workers (PSW) confirmed that they had used the incorrect mechanical lift when they attempted to transfer the resident. Following the attempt to transfer the resident, the resident experience a significant level of pain, was transferred to hospital for assessment where it was determined that the resident sustained an injury that required surgical intervention.

(PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent Critical Incident Inspection Log # H-002784-15) [s. 6. (7)]

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

A) Resident #110 had responsive behaviours which included being socially inappropriate, resistive to care and wandering due to their cognitive impairment. In March, 2015, resident #110 was hospitalized due to an infection and then re-admitted back to the home. A review of the resident's clinical record indicated that after the resident was re-admitted back to the home, the staff had identified that the resident's behaviours had escalated.

A review of the resident's plan of care that staff refer to for direction in providing care, indicated that the resident's responsive behaviour care plan had not been reviewed or revised after identifying that there had been an increase in these behaviours.

It was confirmed by the Administrator during an interview that the resident's responsive behaviour care plan had not been reviewed or revised when the resident's responsive behaviours had escalated after being re-admitted back to the home.

B) A review of resident #104's Minimum Data Set (MDS) coding for a significant change in status that was completed in February, 2015, indicated that the resident was coded as having an infection. A review of the resident's progress notes indicated that they were admitted to hospital in 2015 due to this infection. A review of the resident's written plan of care indicated that no plan was in place to identify the resident's infection including interventions to manage the infection. An interview with the RAI Coordinator confirmed that the resident's written plan of care had not identified the resident's infection including interventions to manage the infection and that the plan of care was not reviewed and revised when their care needs changed. (214)

C) A review of resident #104's Minimum Data Set (MDS) coding that was completed in May, 2015, indicated that the resident demonstrated deterioration in their mood and behaviours as compared to their previous assessment that was completed. A review of the resident's written plan of care indicated under mood state that the most recent revision was made in April 2015, prior to the resident's deterioration in their mood. A review of the resident's written plan of care indicated under behaviours that the most recent revision was made in July, 2014. An interview with the Quality Risk Management Coordinator confirmed that the resident's plan of care was not reviewed and revised when their care needs changed. (214)

D) A review of resident #107's clinical record indicated that the resident had an alteration in their skin integrity on their hand, following a procedure in 2015. The

home's physician ordered a topical antibiotic treatment to be applied to the wound twice daily. According to the resident's progress notes this alteration in their skin integrity had healed. A review of the resident's written plan of care in place at the time of the their alteration in skin integrity indicated under skin conditions that the resident's skin would remain intact and had not identified any areas of altered skin integrity including interventions to manage any associated infections. An interview with the home's wound care nurse confirmed that the resident's plan of care was not reviewed and revised when their care needs changed. (214)

E) A review of resident #114's Minimum Data Set (MDS) coding for a significant change in status that was completed in April, 2015, indicated that the resident was coded as having an infection. A review of the resident's progress notes indicated that the resident began demonstrating symptoms of an infection. Oxygen therapy was applied for comfort. The physician was notified and an order was received for an antibiotic. A further review of the resident's progress notes indicated that the resident's symptoms of an infection had resolved. A review of the resident's written plan of care for this time period, indicated that no plan was in place to identify the resident's infection including interventions to manage the infection. An interview with the Quality Risk Management Coordinator confirmed that the resident's written plan of care had not identified the resident's infection including interventions to manage the infection and that the plan of care was not reviewed and revised when their care needs changed. (214)

F) A review of resident #114's Minimum Data Set (MDS) coding that was completed in April, 2015, indicated that the resident demonstrated a decline in their communication since their previous MDS coding and that their decline was specific in their ability in making self-understood as well as in their ability to understand others. A review of the resident's written plan of care in April, 2015, indicated that no plan was in place for the resident's decline in their communication. An interview with the Quality Risk Management Coordinator confirmed that no plan was in place for the resident's decline in their communication and that the plan of care was not reviewed and revised when the resident's care needs changed. (214)

G) i) Staff and clinical documentation confirmed that resident #102's plan of care was not reviewed and revised when the resident began demonstrating signs and symptoms of an infection. Clinical documentation indicated that on an identified date in 2015, registered staff were called to assess the resident and at that time the resident told staff they were short of breath and coughing thick mucus. Staff monitored the resident's vital signs and noted that oxygen saturations were low and began the

administration of oxygen. Clinical documentation continued to indicate that the resident received oxygen therapy on a continuous basis, was placed on a course of antibiotics, complained of feeling unwell, and demonstrated a decrease in physical activity. The Resident Assessment Protocol (RAP) indicated that the resident had an infection. Staff and clinical documentation confirmed that directions for the care of resident #102 were not reviewed or revised and the plan of care did not contain directions for the use of oxygen or the requirement for ongoing monitoring of the resident's status. (129)
G) ii) Staff and clinical documentation confirmed that resident #102's plan of care was not revised when staff assessed the resident and documented on a Minimum Data Set (MDS) review that the resident was dehydrated. Staff documented on the associated Resident Assessment Protocol (RAI), completed on the same date, that this issue would be care planned with the goal for improvement. The Registered Dietitian confirmed that the resident's target fluid intake had been assessed. Documentation of fluid intake indicated that resident #102's fluid intake had deteriorated from the previous month when staff documented that the resident consumed three quarters or less of the required fluid amount on seven days and consumed one half or less of the required fluid on 19 of the 30 days. Staff and clinical documentation confirmed that the resident's care plan was not revised and did not contain strategies to manage the resident's deteriorating hydration status.

G) iii) Staff and clinical documentation confirmed that resident #102's plan of care was not reviewed or revised when staff assessed the resident and documented on a MDS review that the resident was "bedfast". Staff and clinical documentation confirmed that the resident's plan of care was not reviewed or revised to include directions for staff in providing hygiene care, care related to bowel and bladder elimination, care related to the management of skin breakdown or care related to social and recreational needs while the resident remained in bed. [s. 6. (10) (b)]

7. The licensee has 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 of care had not been effective.

Resident #110 was identified as a high risk for falls and interventions had been developed to minimize the risk of falls in early 2014. A review of the resident's clinical record between February to August, 2015 indicated that the resident had eight falls during this time period. The resident sustained an injury due to one of these falls.

A review of the resident's plan of care indicated that the falls interventions had not

been reviewed or revised until after the resident had fallen six times.

It was confirmed during an interview on August 28, 2015, with the RAI Co-ordinator that the falls interventions developed in 2014, had not been effective and the plan of care had not been reviewed or revised until after the resident had fallen six times. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 003, 004, 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003,004,005,006

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs were fully promoted and respected.

It was observed by the LTC Inspector on August 26, 2015, on the first floor unit that staff were providing care to resident #203 in the resident's room with the door ajar and privacy curtains were not drawn. Staff were observed by the LTC Inspector applying a brief to the resident while the resident was in bed. Staff were immediately notified by the LTC Inspector that the care they were providing to resident #203 could be visibly observed from the hallway.

Staff confirmed that they should have provided privacy to resident #203 while providing care to the resident. [s. 3. (1) 8.]

2. The licensee did not ensure that resident's right to have their personal health information kept confidential was respected, in relation to the following: [3(1) 11 iv]

On August 17, 2015 during a tour of the first floor home area, binders that staff use to document care for the residents where noted to be stored in the hallways on carts under Point of Care (POC) terminals on both the north and south wings. These binders were open on the top of the carts and contained the names of all the residents who live on this home area as well as personal health information related to bowel and bladder function and care related to continence management. [s. 3. (1) 11. iv.]

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 rights of residents to be cared for in a manner consistent with their needs are fully respected and promoted., to be implemented voluntarily.

WN #5: 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 in accordance with evidenced based practices to minimize the risk to the resident. Evidenced based practices have been identified by the Ministry of Health and Long Term care as those developed by Health Canada related to bed safety.

On August 26, 2015 resident #300 was noted to be lying in bed and two quarter bed rails were noted to be in the active position and placed in the middle on both sides of the bed. The registered staff person in attendance at the time indicated that the bed rails had been place on the bed following the resident's return from hospital in 2015. Staff and clinical documentation confirmed that there was not an assessment of the resident completed prior to the use of the bed rails. The DOC confirmed she was unaware of the evidenced base practice guidelines titled "Clinical Guidelines for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada) [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used the resident is assessed in accordance with evidenced based practices to minimize the risk to the resident., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home, in relation to the following: [24]

Staff did not ensure that a 24-hour admission care plan was developed for resident #301 who was admitted to the home in 2015. Staff and the clinical record confirmed that there was not a care plan developed to communicate interventions for care or the specific care needs of the resident.

(PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent Complaint inspection log # H-002264-15) [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care

Specifically failed to comply with the following:

s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the initial plan of care for resident #301 was developed within 21 days of admission, in relation to the following: 25(1)(b)

Resident #301 was admitted to the home in early 2015 and staff confirmed that within 21 days of the resident's admission directions for care where not developed and available to staff for the resident's medical condition and specific care needs. A wound assessment completed upon admission indicated the resident had a pressure ulcer; however, a plan of care was not developed to manage this identified care need. Resident Assessment Protocols (RAP) completed in January, 2015 indicated the resident had numerous care needs, however, plans of care were not developed and available to staff to manage these identified care needs. [s. 25. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the initial plan of care is developed within 21 days of admission, to be implemented voluntarily.

WN #8: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A review of resident #107's clinical record indicated that the resident had an alteration

in their skin integrity, following a procedure in 2015. A review of the resident's clinical record indicated that a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, was not completed for the resident's altered skin integrity. An interview with the home's wound care nurse confirmed that this assessment had not been completed. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was 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 were implemented.

A review of resident #107's clinical record indicated that the resident had an alteration in their skin integrity to their hand, following a procedure in 2015. A review of the resident's clinical record indicated that a referral to the Registered Dietitian (RD) had not been completed. The home's wound care nurse confirmed that a referral had not been completed and the resident was not assessed by the dietitian when they exhibited an alteration in their skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #107's clinical record indicated that the resident had an alteration in their skin integrity, following a procedure in 2015. A review of the resident's progress notes indicated that this alteration in their skin integrity had healed a month later. A review of the resident's clinical record and confirmed by the home's wound care nurse, indicated that no weekly re-assessments of the identified area of altered skin integrity had been completed by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

4. The licensee failed to ensure that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition. [50 (2) (d)]

Resident #102 confirmed that at the time of this inspection staff assisted them into a wheelchair prior to breakfast and they remain in the wheelchair until bedtime in the evening. The resident confirmed that staff did not assist the resident to reposition while they were sitting in the wheelchair. The plan of care for resident #102 indicated

the resident had a care focus related to a risk for ulcer due to immobility and excoriation and that the resident required a specialized surface with sitting in the wheelchair as well as a specialized surface while in bed to manage this risk. Registered staff confirmed that the resident would be unable to reposition themselves while sitting in the chair, the plan of care for the resident does not direct staff to reposition the resident every two hours and that staff are not assisting the resident to reposition every two hours while the resident is sitting in the wheelchair. [s. 50. (2) (d)]

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 be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home had received training as required by this section and in accordance with r. 221(1) 1, in falls prevention and management.

A review of the home's education attendance records related to falls and falls prevention indicated that only 55% of the front line staff had attended the this training in 2014.

It was confirmed during an interview with the Quality Risk Management Co-ordinator on August 31, 2015, that not all of the front line staff working in the home attended the falls prevention and management training in 2014. [s. 76. (7) 6.]

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 staff at the home receive training as required by this section and in accordance with r. 221(1) in falls prevention and management., to be implemented voluntarily.

WN #10: 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:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a response was made to a person who made the complaint, indicating what the licensee has done to resolve the complaint, in relation to the following: [101(1) 3 i]

Resident #109 confirmed that the Director of Care (DOC) did not provide a response to a verbal complaint made related to the approach and demeanor of an identified staff person while providing care to residents. During the course of this inspection resident #109 indicated that they had a concern and had reported this concern to the DOC. During an interview with the DOC, the DOC indicated that she did not recall the discussion the resident had with her, but indicated that it was likely that the discussion occurred as she has spoken to the identified staff person several times. The DOC indicated she was sure she followed up with the resident about the concern that was raised, because she speaks with this resident very regularly. The DOC was unable to produce any documentation to confirm that a response was made to resident #109 in regards to concerns raised about this staff persons approach to care. [s. 101. (1) 3. i.]

2. The licensee failed to ensure that the document record kept in the home of complaints made included; the type of action taken to resolve the complaint, including the date of the action, time frames for action to be taken and any follow-up action required; the final resolution, if any, and every date on which any response was provided to the complainant and a description of the response. [101(2)]

A review of the home's complaint log for 2015 indicated that the home did not comply with the regulations requiring specific information to be included in the written record, in relation to the following:
A) February 2015
-A complaint logged related resident behaviour did not contain the date the complaint was lodged, the time frame for actions identified, final resolution or information about a response provided to the complainant.
B) April 2015
-A complaint logged related to concerns from a resident about a staff member did not contain the date of the action was taken, final resolution or information about a response provided to the complainant.
-A complaint logged related to a resident's pain control and missing laundry did not contain the dates action was taken, final resolution or information about a response provided to the complainant.
C) May 2015
- A complaint logged related to a resident falling did not contain the date action was taken or information about a response provided to the complainant.
-A complaint logged related to a resident falling, bruising, call bell response times and assistance for resident to eat did not contain information about the type of action taken to resolve the issue, the date action was taken, the final resolution or information about a response provided to the complainant.
D) June 2015
-A complaint logged related to concerns about a roommate and a wheelchair did not contain information about the actions taken to resolve the issues, the date action was taken, the final resolution or information about a response provided to the complainant.
-A complaint logged related to resident behaviour and room change did not contain information about actions taken, final resolution or information about a response provided to the complainant.
E) August 2015
-A complaint related to a staff person did not contain the dates action was taken
-A complaint related to related to resident/staff interaction did not contain the date action was taken, the final resolution or information about a response provided to the

complainant.
-A complaint related to personal property damage did not contain the date action was taken, the final resolution or information about a response provided to the complainant. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a response is made to a person who made the complaint, indicating what the licensee had done to resolve the complaint., 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 has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A) It was observed during the stage one observation on August 19, 2015, that in room #131, there was a denture cup, three toothbrushes and a urinal in a bathroom shared by two residents with no labels to identify who these items belonged to.

In room #132, two toothbrushes were observed inside the bathroom cabinet shared by two residents with no labels.

In room #123 in a bathroom shared by two residents, an unlabeled urinal was lying on the floor near the toilet with a substance on the bottom which resembled urine.

Front line nursing staff confirmed during an interview on August 19, 2015, that the resident's personal items should have been labeled to minimize the risk of cross contamination as these were identified in shared bathrooms.

B) During a tour of the home on August 19, 2015 the following was observed:

In room #201 a blue plastic fracture pan was observed to have been stored on the bathroom floor beside the toilet in a shared washroom and unlabeled. An interview with front line nursing staff confirmed that the fracture pan was not stored properly and was to be labeled.

In room #213 a catheter bag was observed to be hanging under the bathroom sink over the shut off valves. A yellow coloured liquid was present in the catheter bag and the tubing. The end of the tubing was observed to be opened and not capped. An interview with front line nursing staff confirmed that the catheter bag was not to be stored in this manner and discarded the catheter bag.

In room #214, in a shared resident's bathroom, an unlabeled urinal was observed to be hanging on a grab bar. An interview with front line nursing staff confirmed that the urinal was not stored properly and was to be labeled.

In room #230, in a shared resident's bathroom, two blue wash basins were observed stored between the grab bar and the wall and both were unlabeled. An interview with front line nursing staff confirmed that the wash basins were not stored properly and were to be labeled. [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 participate in the implementation of the infection prevention and control program., to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the written procedures for the management of complaints complied with the regulations for how the licensee deals with complaints, in relation to the following: [21]

The Administrator and the home's policy confirmed that the policy titled" Complaints", identified as # 09-04-06 and dated June 2010 stated; "verbal complaints that can resolved within 24 hours do not require a written investigation report". This statement does not comply with O.Reg. 79/10, s. 101(2) which requires that a documented record of every verbal or written complaint made to the licensee is to be kept in the home. [s. 21.]

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. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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 the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) A review of the home's annual Quality Program Evaluation for Falls reviewed by the home in September, 2014, identified that there had been an increase in resident falls in resident bathrooms around toilets.

A summary of the changes made and a list of actions developed by the Falls Committee based on their analysis, had not been completed. The statement documented in this section of the evaluation was that they would 'look at solutions for bathroom related falls'.

A summary of changes made and the date that any changes were implemented had not been included. An interview with the Quality Risk Management Coordinator confirmed that the annual program evaluation had not been included all of the required information.

B) A review of the home's annual program evaluation for the Skin and Wound Care Program 2014 indicated the date of the evaluation and the names of the persons who participated in the evaluation; however, had not included a summary of the changes made and the date that any changes were implemented. An interview with the Quality Risk Management Coordinator confirmed that the annual program evaluation had not included all of the required information. (214) [s. 30. (1) 4.]

2. 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.

A review of resident #107's clinical record indicated that the resident had an alteration in their skin integrity, following a procedure in 2015. The home's physician ordered a treatment to be applied to the wound twice daily. A review of the resident's Electronic Medication Assessment Record (EMAR) indicated that the resident received 12 applications of the topical antibiotic treatment and on an identified date in 2015, the topical antibiotic treatment was placed on hold. A review of the resident's clinical record did not contain any documentation as to why the treatment was placed on hold. An interview with the home's wound care nurse confirmed that the actions to hold the treatment were not documented. [s. 30. (2)]

Issued on this 20 day of January 2016 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : ROSEANNE WESTERN (508) - (A1)

Inspection No. / No de l'inspection : 2015_247508_0014 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-003010-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 20, 2016;(A1)

Licensee / Titulaire de permis :
EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD :
EXTENDICARE ST. CATHARINES
283 Pelham Road, St. Catharines, ON, L2S-1X7

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

Ministère 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : JANE FREEMAN

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_191107_0022, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

(A1)
The licensee shall ensure that procedures and interventions are developed and
implemented to assist residents, including resident #106, and staff who are at
risk or who are harmed as a result of a resident s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially
harmful interactions between and among residents.

The licensee shall,

1. review resident #106 s plan of care to ensure that current interventions are effective and revise as required.

2. update resident #106 s plan of care to include interventions to minimize risk of
harm or altercations towards co-residents.

3. review all of the plans of care for residents with responsive behaviours to ensure
that current interventions are effective and revise as required.

4. educate registered and non-registered staff on managing residents with responsive behaviours, the home s responsive behaviour policy and the internal
process of reporting incidents of resident to resident altercations related to responsive behaviours.

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

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

Grounds / Motifs :

1. Previously issued as a compliance order on September 18, 2014.

The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #106 exhibited responsive behaviours that included wandering, resistiveness to care and inappropriate behaviours towards co-residents and visitors.

A review of the resident's plan of care indicated that the interventions developed to manage the resident's inappropriate behaviours did not include interventions to minimize risk of harm or altercations towards other residents, only visitors.

It was confirmed during an interview with the RAI Co-ordinator on August 28, 2015, that the resident had a history of being inappropriate towards co-residents and that interventions had not been developed or implemented to minimize the risk of harm or altercations and potentially harmful interactions between and among residents. [s. 55. (a)]

(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Mar 01, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

(A1)
The licensee shall ensure that staff review and comply with the home s policies and programs, including the following:

1. Oxygen
2. Falls Prevention and Management
3. Palliation Care and Death
4. Food and Fluid Intake Monitoring
5. Mechanical Lifts
6. Bed Entrapment and Proper Use of Bed rail Devices

Grounds / Motifs :

1. Previously issued as a VPC on July 18, 2013 and on September 18, 2014.

The licensee failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A review of resident's #114's progress notes indicated that the resident began demonstrating symptoms of an infection and required oxygen. The resident's progress notes also indicated that they received oxygen therapy via nasal cannula at a specified rate on several occasions.

A review of the home's policy titled, Oxygen (04-06-01 with a revision date of September 2010) indicated the following:

i) Oxygen will be administered to residents in a safe manner where there is a Physician or Nurse Practitioner's order or in emergency situations pending a Physician/Nurse Practitioner's order.

ii) Under Documentation, the care plan is to list oxygen therapy (flow rate, method and duration) under Special Orders/Monitoring and list measures to be taken to provide specific safety measures, client related personal care or teaching.

A review of the resident's Electronic Medication Assessment Record (EMAR) indicated that no orders had been obtained by the physician or the Nurse Practitioner for the administration of oxygen. A review of the resident's written care plan indicated that no documentation for oxygen therapy including the flow rate, method, duration, specific safety measures or related personal care or teaching had been documented and the care plan did not contain a focus for Special Orders/Monitoring. An interview with the Quality Risk Management Coordinator confirmed that no orders had been obtained for the resident's oxygen therapy; the care plan did not contain documentation relative to the oxygen therapy provided and that the home had not complied with their policy. (214)

(214)

2. The licensee failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A review of resident #104's clinical record indicated that they were admitted to the hospital on an identified date in 2015. A review of the resident's progress notes indicated that the resident returned back to the home and received oxygen therapy via nasal cannula at a specified rate.

A review of the home's policy titled, Oxygen (04-06-01 with a revision date of September 2010) indicated the following:

i) Oxygen will be administered to residents in a safe manner where there is a Physician or Nurse Practitioner's order or in emergency situations pending a Physician/Nurse Practitioner's order.

ii) Under Documentation, the care plan is to list oxygen therapy (flow rate, method and duration) under Special Orders/Monitoring and list measures to be taken to provide specific safety measures, client related personal care or teaching.

A review of the resident's Best Possible Medication History Reconciliation/Admission Orders that were completed as well as a review of the resident's Electronic Medication Assessment Record (EMAR) indicated that no orders had been obtained by the physician or the Nurse Practitioner for the administration of oxygen. A review of the resident's written care plan indicated that no documentation for oxygen therapy including the flow rate, method, duration, specific safety measures or related personal care or teaching had been documented and the care plan did not contain a focus for Special Orders/Monitoring. An interview with the RAI Coordinator confirmed that no orders had been obtained for the resident's oxygen therapy; the care plan had not contained documentation relative to the oxygen therapy provided and that the home had not complied with their policy. (214)

(214)

3. The licensee failed to ensure that where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol,

procedure, strategy or system, the direction contained in those documents was complied with, in relation to the following: [8(1) (b)]

A) Staff did not comply with directions contained in the home's "Oxygen" policy identified as # 04-06-01 and dated September 2010, in relation to the following:
i) This policy directed that "Oxygen will be administered to residents in a safe manner where there is a Physician or Nurse Practitioner's order".
- Staff did not comply with this direction when they administered oxygen to resident #102 without an order for oxygen to be administered. Staff and clinical documentation confirmed that the resident received oxygen on a continuous basis at a specified rate on six occasions in 2015 without a physician or nurse practitioner's order.
ii) This policy directed that staff where to document in the care plan "a list of oxygen therapy (flow rate, method and duration) and list measures to be taken to provide specific safety measures, client related personal care or teaching". Staff and clinical documentation confirmed that this direction was not complied with for resident #102. Staff administered oxygen to this resident in 2015 and the resident's care plan did not contain any indication the resident was receiving oxygen on a continuous basis or identified any safety measures that were to be put in place related to the use of oxygen therapy.

B) Staff did not comply with the directions contained in the "Palliative Care and Death" policy identified as #RESI-04-04-04 and dated December 2002. Directions contained in this policy indicated that "a written order is required, from discussions of advanced directive, by the attending physician to provide palliative care in the facility".
- Staff and clinical documentation confirmed that this direction was not complied with, when an MDS review completed for resident #105 in early 2015 indicated that the stability of the resident's condition at the time was "End stage disease". The staff person making this documentation confirmed that there was not a physician order in either the computerized record or the hand written record to indicate that resident #105's care focus had changed and was now identified as palliative care.

C) Staff did not comply with the home's policy "Food and Fluid Intake monitoring" identified as RESI-05-02-05 and dated September 2014. This policy directed that "if a resident consumes less than their minimum fluid target levels for three consecutive days, the resident requires a hydration assessment and the hydration assessment must be documented".

- Staff and clinical documentation confirmed that this direction was not complied when clinical records indicated that resident #102 had not consumed their minimum fluid target levels for 31 days on an identified date in 2015 and 30 days a month later in 2015 and a hydration assessment was not completed.
- Staff and clinical documentation confirmed that this direction was not complied with when clinical records indicate that resident #105 had not consumed their minimum fluid target levels on three occasions in 2014 and eight occasions in early 2015 and hydration assessments were not completed during these periods of time.

D) Staff did not comply with the home's policy "Mechanical Lifts" identified as #01-02 and revised on May 2009. This policy directed that residents are assessed with any change in condition and each assessment includes an evaluation of the assistance required to transfer safely from one surface to another.
- Staff and clinical documentation confirmed that this direction was not followed when on an identified date in 2015 the plan of care indicated that resident #300's method of transfer was changed. The resident was now being transferred with the use of a total mechanical lift when previously the resident was being transferred with a sit-to-stand lift. Restorative care staff who made this change to the plan of care confirmed that there was not a documented assessment of the resident. -Staff did not comply with the home's policy "Bed Entrapment and Proper Use of Bed rail Devices", identified as # 08-10-01 and dated April 2011. This policy directed that a reassessment of the resident is to be completed as needs change or with any significant change in condition.
- Staff and clinical documentation confirmed that this direction was not followed when upon return from hospital in 2015, two quarter bed rails were affixed to resident #300's bed in the absence of an assessment of the resident's needs. Registered staff confirmed that there is not a documented assessment of the resident to determine the appropriate bed system for this resident. [s. 8. (1)]

(129)

4. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

Resident #200 had several falls in the home which resulted in the resident sustaining an injury. The resident's family member had called the home with concerns related to the circumstances of the resident's fall.

A review of the home's Complaints policy, dated June 2010, indicated that for verbal complaints not resolved within 24 hours, a written record of the complaint as well as the investigation and the outcome will be retained by the home.

The home's 2015 complaint log contained some documentation around this family member's concern; however, there was not a written record of the investigation of the incident or the outcome.

It was confirmed by the Administrator on August 25, 2015, that the written record of the complaint in the 2015 complaint log did not contain the investigation or the outcome of the complaint.

(PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent complaint Log # H-002486-15) (508)

5. Resident #200 had a fall on an identified date in 2014, and a post fall assessment was completed by staff that same day. A review of the resident's clinical record indicated that after the post fall assessment had been completed and documented, the resident was not reassessed for injuries or changes in condition related to their fall.

A review of the home's policy titled, Falls Prevention and Management Program (10-02-01), dated April, 2013, directs registered staff to complete an ongoing assessment of the resident for a minimum of 72 hours after a fall. Each shift the resident is to be assessed for pain, bruising, change in functional status, change in cognitive status and changes in range of motion. All assessments and actions during the 72 hour post fall follow-up are to be documented in the progress notes.

There were no further assessments conducted or documented after the initial post fall assessment was completed.

It was confirmed by the RAI Co-ordinator during an interview on August 28, 2015, that staff did not comply with the home's Falls Prevention and Management Program when the resident had not been reassessed each shift within the 72 hours post fall.

(PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent complaint Log # H-002486-15)

(508)

6. Resident #110 was identified as a high risk of falls in 2014 and continued to have falls in early 2015. On an identified date in 2015, resident #110 was transferred to hospital. The resident was re-admitted to the home and had been identified as having a significant change in status due to the resident's decline.

A review of the home's policy titled, Falls Prevention and Management Program (10-02-01), dated April, 2013, directs the staff to complete a Morse Fall risk assessment within 24 hours upon admission for all residents. Ongoing, complete a Morse Fall assessment for a resident at the time of significant change in resident status.

A review of the resident's clinical record indicated that the resident had a significant change in status, however, a Morse Fall risk assessment had not been conducted. The resident had another fall after being re-admitted to the home.

It was confirmed by the RAI Co-ordinator during an interview on August 28, 2015, that the Falls Prevention and Management Program had not been complied with.

(508)

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

Mar 01, 2016(A1)

LTCHA, 2007, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

(A1)
The licensee shall ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to residents, including resident #200.

The licensee shall,

1. review the plan of care for resident #200 and update the plan to include clear
directions and interventions for staff to minimize the resident s risk for falls.

2. review the falls care plan for all residents who are identified as a high risk for
falls and ensure that there are clear directions for staff who provide direct care to
these residents.

3. provide training to all direct care staff on the home s Falls Prevention and Management Program.

Grounds / Motifs :

(A1)
1. The licensee had failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Resident #200 had been identified as a high risk for falls and had three falls between November, 2014 - April, 2015. The resident sustained a fracture after the third fall on April 30, 2015. Post fall assessments conducted after each of these falls identified that the resident had fallen due to tripping on his pants as they were to long.

After the resident s second fall in February, 2015, the home sent out the resident s pants to have them hemmed to minimize his risk of falling again. Two pairs of the resident s pants were not sent out as they were in the laundry at the time all of the resident s pants were collected to be hemmed.

Staff separated the two pairs of pants that were to long for the resident from the pants that had been hemmed, however; they remained in the resident s room. On April 30, 2015, a staff member assisted the resident with dressing and put the pants on the resident that had not been hemmed. Later that day the resident tripped on his pants which resulted in the resident fracturing his ankle.

A review of the resident s plan of care that staff refer to for direction in providing care to residents, did not indicated that staff were to ensure the resident was wearing proper fitting pants to minimize the risk of falling. The only intervention under the falls focus was to ensure a safe environment i.e. floor surfaces even, glare free lighting, bed in lowest position, personal items with reach.

It was confirmed by the RAI-Co-ordinator on August 28, 2015, that the written plan of care for resident #200 did not set out clear directions to staff and others who provided direct care to the resident. (508)

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

Mar 01, 2016(A1)

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

Ministère 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 : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
The licensee shall ensure that the care set out in the resident s plan of care is provided to the resident as specified in the plan.

Grounds / Motifs :

1. 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, in relation to the following: [6(7)]

Staff and clinical documentation confirmed that the care set out in resident #300's plan of care was not provided as specified in 2015, when staff used a mechanical lift that had not been approved for use by the resident based on the resident's changing needs. Staff and the clinical record confirmed that on an identified date in 2015, restorative care staff identified that the resident's ability to stand and bear weight had deteriorated, that the sit-to-stand mechanical lift was no longer safe for the resident to use and the plan of care was changed to indicate that a total mechanical lift with full sling was to be used for all transfers of the resident. A registered staff member who was asked to assess the resident following the attempt to transfer the resident due to a high level of pain the resident experienced, confirmed that staff had used the incorrect mechanical lift. During interviews conducted by the home two Personal Support Workers (PSW) confirmed that they had used the incorrect mechanical lift when they attempted to transfer the resident. Following the attempt to transfer the resident, the resident experience a significant level of pain, was transferred to hospital for assessment where it was determined that the resident sustained an injury that required surgical intervention.

(PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent Critical Incident Inspection Log # H-002784-15) [s. 6. (7)]

(129)

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

Resident #106 had responsive behaviours that included inappropriate behaviours towards co-residents and visitors. The resident's plan of care indicated that all staff, in all departments were to closely monitor the resident whereabouts and behaviours when certain identified visitors were present in the building.

It was observed by the LTC Inspector during this inspection, that these identified visitors were in the home for an activity on the unit where resident #106 resided. These visitors had been on or near the unit greater than 15 minutes during this observation. Two staff members working on the unit near the visitors were asked by the LTC Inspector if they knew where resident #106 was. The staff responded that they did know where the resident was and then asked the LTC Inspector if the resident was in their room. There were no other staff members visible on the unit during this time.

The LTC Inspector approached the resident's room and observed the resident standing alone in their room. There were no staff observed in the hallway or near the resident's room. The LTC Inspector then immediately notified the DOC that the resident was not being monitored during the time that the visitors were in the building and that staff were not aware of the resident's whereabouts during this time.

It was confirmed by the DOC on August 26, 2015, that resident #106 should have been closely monitored by staff during the time the visitors were in the building.

(508)

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

Mar 01, 2016(A1)

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

Ministère 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 : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

(A1)
The licensee shall ensure that when residents are reassessed, resident s care needs change or care set out in the plan is no longer necessary that the plan of care is reviewed and revised.

The licensee shall,

1. educate staff to ensure that when residents care needs change, such as when a resident has an infection, changes in their responsive behaviours, communication needs and changes with skin and wound, that their plan of care is reviewed and revised.

Grounds / Motifs :

1. The licensee failed to ensure that when the resident is reassessed the plan of care was reviewed and revised when the resident's care needs change, in relation to the following: [6(10) (b)]

Staff and clinical documentation confirmed that resident #102's plan of care was not reviewed and revised when the resident began demonstrating signs and symptoms of an infection. Clinical documentation indicated that on an identified date in 2015, registered staff were called to assess the resident and at that time the resident told staff they were short of breath and coughing thick mucus. Staff monitored the resident's vital signs and began the administration of oxygen. Clinical documentation continued to indicate that the resident received oxygen therapy on a continuous basis, was placed on a course of antibiotics, complained of feeling unwell, and demonstrated a decrease in physical activity. The Resident Assessment Protocol (RAP) indicated that the resident had an infection. Staff and clinical documentation confirmed that directions for the care of resident #102 were not reviewed or revised and the plan of care did not contain directions for the use of oxygen or the requirement for ongoing monitoring of the resident's status. (129)

Staff and clinical documentation confirmed that resident #102's plan of care was not revised when staff assessed the resident and documented on a Minimum Data Set (MDS) review that the resident was dehydrated. Staff documented on the associated Resident Assessment Protocol (RAI), completed on the same date, that this issue would be care planned with the goal for improvement. The Registered Dietitian confirmed that the resident's target fluid intake had been assessed. Documentation of fluid intake for one month in 2015, indicated the resident did not consume 21 glasses of fluid on any of the 30 days of this month. Documentation of fluid intake indicated that resident #102's fluid intake had deteriorated from the previous month when staff documented that the resident consumed three quarters or less of the required fluid amount on seven days and consumed one half or less of the required fluid on 19 of the 30 days. Staff and clinical documentation confirmed that the resident's care plan was not revised and did not contain strategies to manage the resident's deteriorating hydration status.

Staff and clinical documentation confirmed that resident #102's plan of care was not reviewed or revised when staff assessed the resident and documented on a MDS review that the resident was "bedfast". Staff and clinical documentation confirmed that the resident's plan of care was not reviewed or revised to include directions for staff in providing hygiene care, care related to bowel and bladder elimination, care related to the management of skin breakdown or care related to social and recreational needs while the resident remained in bed. [s. 6. (10) (b)]

(129)

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

A review of resident #114's Minimum Data Set (MDS) coding that was completed in April, 2015, indicated that the resident demonstrated a decline in their communication since their previous MDS coding and that their decline was specific in their ability in making self-understood as well as in their ability to understand others. A review of the resident's written plan of care in April, 2015, indicated that no plan was in place for the resident's decline in their communication. An interview with the Quality Risk Management Coordinator confirmed that no plan was in place for the resident's decline in their communication and that the plan of care was not reviewed and revised when the resident's care needs changed. (214)

(214)

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

A review of resident #114's Minimum Data Set (MDS) coding for a significant change in status that was completed in April, 2015, indicated that the resident was coded as having an infection. A review of the resident's progress notes indicated that the resident began demonstrating symptoms of an infection. Oxygen therapy was applied for comfort. The physician was notified and an order was received for an antibiotic. A further review of the resident's progress notes indicated that the resident's symptoms of an infection had resolved. A review of the resident's written plan of care for this time period, indicated that no plan was in place to identify the resident's infection including interventions to manage the infection. An interview with the Quality Risk Management Coordinator confirmed that the resident's written plan of care had not identified the resident's infection including interventions to manage the infection and that the plan of care was not reviewed and revised when their care needs changed. (214)

(214)

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

A review of resident #107's clinical record indicated that the resident had an alteration in their skin integrity, following a procedure in 2015. The home's physician ordered a topical antibiotic treatment to be applied to the wound twice daily. According to the resident's progress notes this alteration in their skin integrity had healed. A review of the resident's written plan of care in place at the time of the their alteration in skin integrity indicated under skin conditions that the resident's skin would remain intact and had not identified any areas of altered skin integrity including interventions to manage any associated infections. An interview with the home's wound care nurse confirmed that the resident's plan of care was not reviewed and revised when their care needs changed. (214)
(214)

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 the resident's care needs change or care set out in the plan was no longer necessary.

A review of resident #104's Minimum Data Set (MDS) coding that was completed in May, 2015, indicated that the resident demonstrated deterioration in their mood and behaviours as compared to their previous assessment that was completed. A review of the resident's written plan of care indicated under mood state that the most recent revision was made in April 2015, prior to the resident's deterioration in their mood. A review of the resident's written plan of care indicated under behaviours that the most recent revision was made in July, 2014. An interview with the Quality Risk Management Coordinator confirmed that the resident's plan of care was not reviewed and revised when their care needs changed. (214)

(214)

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

A review of resident #104's Minimum Data Set (MDS) coding for a significant change in status that was completed in February, 2015, indicated that the resident was coded as having an infection. A review of the resident's progress notes indicated that they were admitted to hospital in 2015 due to this infection. A review of the resident's written plan of care indicated that no plan was in place to identify the resident's infection including interventions to manage the infection. An interview with the RAI Coordinator confirmed that the resident's written plan of care had not identified the resident's infection including interventions to manage the infection and that the plan of care was not reviewed and revised when their care needs changed. (214)

(214)

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

Resident #110 had responsive behaviours which included being socially inappropriate, resistive to care and wandering due to their cognitive impairment. In March, 2015, resident #110 was hospitalized due to an infection and then re-admitted back to the home. A review of the resident's clinical record indicated that after the resident was re-admitted back to the home, the staff had identified that the resident's behaviours had escalated.

A review of the resident's plan of care that staff refer to for direction in providing care, indicated that the resident's responsive behaviour care plan had not been reviewed or revised after identifying that there had been an increase in her behaviours.

It was confirmed by the Administrator during an interview that the resident's responsive behaviour care plan had not been reviewed or revised when the resident's responsive behaviours had escalated after being re-admitted back to the home. (508)

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

Mar 01, 2016(A1)

Order # /
Ordre no : 006

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall reassess the plan of care for resident #110, and residents that have been identified as a high risk for falls and revise their plans if care set
out in the plan has not been effective.

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

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

Grounds / Motifs :

1. The licensee has 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 of care had not been effective.

Resident #110 was identified as a high risk for falls and interventions had been developed to minimize the risk of falls in early 2014. A review of the resident's clinical record between February to August, 2015 indicated that the resident had eight falls during this time period. The resident sustained an injury due to one of these falls.

A review of the resident's plan of care indicated that the falls interventions had not been reviewed or revised until after the resident had fallen six times.

It was confirmed during an interview on August 28, 2015, with the RAI Co-ordinator that the falls interventions developed in 2014, had not been effective and the plan of care had not been reviewed or revised until after the resident had fallen six times. [s. 6. (10) (c)]

(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Mar 01, 2016(A1)

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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 20 day of January 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ROSEANNE WESTERN - (A1)

Service Area Office /
Bureau régional de services : Hamilton