Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 19, 2016	2016_265526_0010	013027-16	Resident Quality Inspection

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

FAITH MANOR NURSING HOME
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

THERESA MCMILLAN (526), HEATHER PRESTON (640), JESSICA PALADINO (586), JULIEANN HING (649), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 10, 11, 12, 13, 16, 17, 18, 19, 20, 24, 25, 26, 27, 30, 31, June 1, 2, 3, 7, and 8, 2016.

The following Complaint inspections were conducted simultaneously during this RQI:
004679-16: Duty to protect; Resident`s rights; Reporting and Complaints
006859-16: Continence; Resident`s Rights; Administration of Drugs

012936-16: Duty to Protect
016795-16: Prevention of Abuse and Neglect

The following Critical Incident inspections were conducted simultaneously during this RQI:
006738-15: Pain management; Falls prevention
022129-15: Reporting matters to the Director; Duty to Protect
032235-15: Duty to protect; Responsive behaviours
001380-16: Falls prevention; Responsive behaviours
016403-16: Prevention of Abuse and Neglect; Reporting and Complaints
016342-16: Duty to Protect
016320-16: Duty to Protect; Responsive behaviours
016803-16: Prevention of Abuse; Reporting certain matters to the Director
016801-16: Prevention of Abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Resident Care (DRC), Assistant Director of Resident Care (ARDC), Resident Assessment Instrument (RAI) Coordinator, Behavioural Support (BSO) Nurse, Health and Safety/Education Coordinator, Housekeeping Manager, Laundry Manager, Maintenance Manager, Dietary Manager, Activation Manager, Social Service Worker, Physiotherapist (PT), physiotherapy assistants (PTA's), Occupational Therapist (OT), Registered Nurses (RN's), Registered Practical Nurses (RPN's), Personal Support Workers (PSW's), Registered Dietitian, dietary aides, housekeeping and maintenance staff, staffing clerk, residents, family members and visitors.

During the course of this inspection, inspectors toured the home; observed residents, staff, and dining service; reviewed health records, policies and procedures, training files, meeting minutes, evaluation files, complaints logs, bed entrapment audits, and maintenance and housekeeping logs.

The following Inspection Protocols were used during this inspection:

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

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

- **29 WN(s)**
- **4 VPC(s)**
- **14 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

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

Resident #041 was prescribed a treatment that they wished to have administered in the dining room and complained to the Long Term Care Homes (LTC) Inspector that some staff would not provide care according to their wishes. Staff interviews confirmed this. Review of health records and interview with Registered Nurse (RN) #106 confirmed that resident #041's wishes had not been included in their written plan of care.The DRC confirmed that resident #041's written plan of care did not include their planned care in relation to their preferences for treatment administration. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) According to health records, resident #041 required extensive assistance from two staff persons and the use of a mechanical lift for transferring. The document the home referred to as their care plan directed staff to use two different types of mechanical lifts. Staff and Director of Resident Care (DRC) interviews confirmed that they were unclear as to which lift to use when transferring resident #041.The DRC said that the lift that was used was dependent upon which staff was transferring the resident. During interview the resident told Long Term Care Homes (LTC) Inspector that they felt afraid when staff transferred them as they felt they might fall.

The DRC confirmed that the directions for direct care staff were unclear in relation to which lift should be used when transferring resident #041 between bed and chair.

B) During interview resident #041 complained to LTC Inspector that they had pain during a standing transfer and were afraid about their safety. During interviews, PSWs #102, #103, and #104 reported to LTC Inspector that they were concerned about the resident's safety during transfer and thought that they should be using a different type of lift. They told the LTC Inspector that they expressed their concerns to registered staff, and that the plan of care was not clear in terms of how to manage safety concerns during transferring and when an alternative transfer strategy would be appropriate. [s. 6. (1) (c)]

3. The licensee failed to ensure that resident #160 was provided with an incontinence product that was of their assessed need and preference. The resident identified the type of brief they would like to use and stated that this was what they wore when they went home to visit with their family. The resident stated the staff applied a different continence product and told them it was easier for them to use and would not provide the resident with their preference. PSW staff confirmed resident used the continence product as described by the resident. The continence assessment was incomplete regarding the preference of the resident. [s. 6. (2)]

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

A) During interviews with LTC Inspectors, resident #015 voiced concern about not being assisted out of bed and provided morning care according to their preference, causing them to be late for breakfast. The resident's documented plan of care indicated their preference. Interviews with PSWs #119 and #111 confirmed that they knew about the resident's preference, however, they were unable accommodate this due to the need to

assist other residents first and dueto the level of care resident #015 required. The staff confirmed the resident's sleep and rest plan of care was not provided to the resident as per their preference to meet their needs. The DRC confirmed care was not provided to the resident as per their plan of care. (586)

B) The licensee failed to ensure that the plan of care for resident #018 was provided as specified in the plan. On a specified day in 2016, the resident demonstrated resistive behaviour to care and the plan of care directed staff to leave the resident and then reapproach with a calm approach. PSW #120 did not follow the plan of care and insisted the resident receive the care, regardless of the verbal and then physical refusals by the resident. The incident resulted in a physical altercation between the resident and PSW #120, where the PSW grabbed the resident's hand, and resulted in the resident sustaining injuries during the altercation. This was confirmed by PSW #120, documentation and the DRC. (169)

C) The licensee has failed to ensure that resident #160 was provided the care as set out in the plan of care. On a specified day in 2016, the resident rang their call bell to go to the washroom. They were observed sitting on the toilet for over ten minutes alone in the washroom. The plan of care confirmed the resident required constant supervision while sitting on the toilet. A recent falls risk assessment confirmed the resident was high risk for falls. PSW caring for the resident on that day, confirmed the care was not provided to the resident, according to the plan of care. (169)

D) Resident #045 fell several times over a 12 month period. Their documented plan of care indicated that they were ambulatory, a high risk for falls and directed staff to implement falls prevention strategies. The post falls analysis conducted after the resident fell on a specified day in 2016, indicated that one of the strategies that had not been implemented was a contributing factor in the resident's fall.

The resident was observed during the course of this inspection without the contributing falls prevention strategy being in place. Interview with Registered Practical Nurse (RPN) #105 confirmed that the strategy had not been implemented for several weeks. Only after this interview did staff begin to implement the falls prevention strategy. Interview with the BSO staff and DRC confirmed the resident should have had the contributing falls prevention strategy in place according to their plan of care in order to reduce their risk of falling. (586)

E) Resident interview and their written plan of care indicated that staff were to maintain

predictable care routines for resident #031. On a specified day in 2016, the resident was observed waiting 25 minutes and 45 minutes to receive care. When asked if this had happened in the past, resident #013 and their roommate #014 told LTC inspector that staff would say something like "I'm late for my break", or “we are really busy right now”. When asked why they didn’t return right away to assist resident #013, PSW #121 told LTC Inspector that they had other residents to care for and didn't think to mention that there would be a delay in getting back to them. They confirmed that care was not provided according to resident #013’s plan of care by keeping them waiting for 20 and then 45 minutes before assisting them to get up without providing reassurance or an explanation about the delay. (526) [s. 6. (7)]

5. The licensee failed to ensure that residents were reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective.

Resident #045, was ambulatory, was at a high risk for falls, and had several falls within a 12 month time period. Their plan of care directed staff regarding falls prevention strategies. Over the course of this inspection, a strategy meant to address a key contributing factor to these falls was observed as not being implemented.

Interview with RPN #115, RPN #105 and the BSO staff and DRC confirmed the resident was non-complaint with the falls prevention strategy, that the intervention was not effective and that the resident would benefit from different falls prevention strategies. The BSO staff confirmed the resident’s plan of care was not reviewed and revised when the care set out in the plan was not effective. [s. 6. (10) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) During interview with resident #041 and their family member, the following was reported to the LTC Inspector throughout the course of this inspection:

i) The resident complained to RN #101 that PSW #100 spoke rudely and disrespectfully to them and that staff were not assisting them to toilet;
ii) The resident complained to the DRC and RN #106 that PSW #100 had not toileted them prior to being put back to bed and did not provide peri care during a brief change after being incontinent when they weren't toileted; the resident stated that they were afraid that they would develop an infection if they weren't clean;
iii) The resident complained to the LTC Inspector that PSW #100 was rude and disrespectful to them; this was reported to RN #106;
iv) The resident's family reported that they provided care since staff would not assist. The LTC inspector observed the resident's family asking for assistance and PSW #126 told them that resident #041 was not their resident and walked away;
v) The resident reported to the LTC inspector, that when PSW #100 saw the LTC inspectors in the home, they said to resident #041, something to the effect: "did you call the ministry to complain? If you did, you won't receive care". This statement could not be verified.
vi) The resident reported to the LTC inspector that the home did not have a zero tolerance of abuse, given the above concerns.

During interview RN #101, reported to the LTC inspector that PSW #100's voice was loud, could be interpreted as rude, but that was the way the staff talked. They stated that resident #041 frequently asked for assistance and that PSW's caring for resident #041 and other residents living in adjacent rooms found it difficult to meet all of the resident's needs and was often asked to wait.

During interview, PSW #100 stated that resident #041 did not like the way they spoke to them and that the resident thought that they were their "private nurse". During interview, the DRC, ADRC, and CEO confirmed that resident #041 and their family member had numerous complaints and sometimes against particular staff persons. The DRC stated that it was difficult to know which complaints were "legitimate". During interview, the DRC, ADRC, and CEO confirmed that the resident's complaints could be interpreted as

abuse and neglect, according to legislative requirements. (526)

B) Resident #019's health condition limited their independence and ability to perform hygiene. According to their health records they required extensive assistance from one staff person for hygiene and had been prescribed a treatment for a skin condition.

During this inspection, resident #019 reported to the LTC Inspector that, during evening care they asked PSW #132 to apply additional cream to the affected area. According to the resident, while the PSW had cream on their hand, they then slapped the resident's hand, wiped cream onto it and told the resident to "Do it yourself!". They stated that they had lost their independence and this act and the way the PSW spoke to them was very upsetting. The resident was observed relaying the same story to the DRC.

The resident also told the LTC Inspector that they had told PSW #111 the following day, about this incident. During interview, PSW #111 stated that resident #019 looked upset and distraught as they reported the alleged abuse to them. They confirmed that the PSW #132's actions constituted abuse.

During interview, PSW #132 confirmed that they had told resident #019 to apply the cream themselves. They confirmed that the resident looked upset after they put the cream on their hand and told them to do it themselves, and that they should have sought the assistance of registered staff.

During interview, the DRC confirmed that the home had failed to protect resident #019 from abuse. (526)

C) The licensee failed to ensure that resident #049 was free from neglect by the licensee or staff. According to their health record, resident #049 was a low risk for falls and ambulated independently in the home; they had responsive behaviours and demonstrated restlessness and resistance to care.

i) On a specified day in 2015, resident #049 lost their balance and fell. According to progress notes it appeared that they had sustained a significant injury to an extremity. The resident's substitute decision maker (SDM) was contacted and asked staff about doing an Xray and managing the resident's pain until the next day. Their pain was not assessed, medication was not administered as prescribed, and a physician or RN in extended class was not informed of the resident's injury. The following morning they were observed to be in pain and their extremity was noticeably injured, at which time they were

sent to hospital for treatment. At that time, a family member informed the ADRC that the SDM was not made fully aware of the extent of the resident's injury. According to progress notes, the ADRC indicated that, given their condition, the resident should have been sent to hospital just after they fell.

According to health records and interview with DRC, registered staff attending to resident #049 the specified day in 2015, evening and night shift neglected to i) conduct a post falls assessment; ii) conduct a pain assessment; iii) administer analgesia as prescribed; iv) notify a physician or RN in extended class of the resident's injury; and v) inform the SDM of the full extent of the resident's injury and did not act on the SDM's request that staff inquire about doing Xray. This was confirmed during interview with the DRC.

ii) The resident was returned to the home after receiving treatment for the injury, had a subsequent fall without injury. They began using a wheelchair for locomotion and was removed from hourly monitoring on a specified day. According to progress notes, after dinner the following day, resident #049 fell again. Post fall assessment and pain assessment were not conducted at that time. The resident was noted to have difficulty moving the same extremity that had been previously injured and staff attributed this to their recent treatment. The resident was transferred back to the wheelchair and taken to the activity room. A physician was not notified of the resident's fall. Regularly scheduled medication was administered.

No further notes regarding the status of the resident's extremity were found until four days later, where the condition of the resident's entire extremity had deteriorated and was visibly injured. The physician was notified, the resident was transferred to hospital and treatment was provided.

When the resident returned to the home four days later, they were receiving regularly scheduled medication and were noted to be lying in bed grimacing one day later. No pain assessment was completed from the time of admission until one week later.

According to health records and interview with DRC, staff attending to resident #049 between the time of their fall and after their return to the home, neglected to i) conduct a post fall assessment; ii) conduct a pain assessment; iii) notify a physician or RN in extended class following the resident's third fall on a specified day in 2015; and iv) assess the resident's extremity when the condition of the extremity had deteriorated.The DRC confirmed that staff neglected to provide resident #049 with treatment, care, services or assistance required for their health and well-being.

D) The licensee has failed to ensure that resident #018 was protected from abuse by staff member #120.

On a specified day in 2016, an incident occurred between the resident and staff member #120 that involved the resident resisting care being provided by the staff member. After the resident resisted receiving care, the staff member grabbed the wrist of the resident to prevent injury to the staff member and in the process, the resident became injured. The morning of the incident, the resident reported to a LTC Inspector that two men had come in and beat them up. The clinical progress notes indicated the incident occurred. The DRC also confirmed the incident occurred. The plan of care directed staff to leave the resident for a few minutes, if they are resistive to care and re-approach with a calm approach. The plan of care was not followed and the resident sustained an injury from the altercation, constituting physical abuse with an injury. (169) [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

Review of the home's "Abuse and Neglect Prevention" policy number NUR-FM-02-01 revised March 15, 2016, directed employees to i) "Immediately report any witnessed, suspected, or alleged abuse to the charge nurse of Director of Resident Care"; and ii) "Document or write a brief factual note (e.g. not allegations or opinion) in chart or patient record writing the details of the alleged or witnessed abuse or neglect as soon as possible".

A) Review of resident #045's clinical health record confirmed that on a specified day in

2016, the resident became agitated and hit resident #027, causing injury. The Assistant Director of Care (ADRC) investigated and confirmed that the RPN who witnessed the abuse and documented the occurrence, did not immediately report the incident to the home's management and to the MOHLTC, and confirmed the home's abuse policy was not complied with. (586)

B) Resident #019 reported to the LTC Inspector that during care on a specified day in 2016, PSW #132 slapped cream into their hand and said "Do it yourself!" and that this had upset them. The resident said that they told PSW #111 the following day. During interview, the DRC confirmed that staff PSW #111 had not mentioned resident #019's allegation of abuse against PSW #132 to them or to registered staff. During interview, PSW #111 confirmed that the resident appeared upset when they told them about the alleged abuse, that the incident was abuse according to the home's policy, and that they had not immediately reported the alleged abuse to the charge nurse or Director of Resident Care according to the home's policy. The DRC confirmed that staff #111 did not comply with the home's "Abuse and Neglect Prevention" policy by not immediately reporting an allegation of abuse.

C) Resident #019 reported to the LTC Inspector that during care on a specified day in 2016, PSW #132 slapped cream into their hand and said "Do it yourself!". The LTC Inspector immediately notified the DRC. The DRC interviewed the resident, confirmed with the LTC Inspector that the resident alleged abuse and described the investigation that was underway. Review of the progress notes revealed that the DRC had not documented the alleged abuse in the resident's health record, according to the home's policy. The DRC confirmed that they should have documented the allegation of abuse in the progress notes according to the home's policy. [s. 20. (1)]

2. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents d) contained an explanation of the duty under section 24 of the Act to make mandatory reports; and e) contained procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

A) Review of the home's "Abuse and Neglect Prevention" policy number NUR-FM-02-01 revised March 15, 2016, indicated the following regarding s. 24 of the Act:

i) that a report was to be "submitted to the MOHLTC within 24 hours by CIS or by telephone on the week-end or holiday; and that a report must be submitted to the MOHLTC within 10 business days" rather than to report immediately according to s.

24(1));
ii)) that the s. 24(1) "requires the facility and certain staff members, to make immediate reports to the MOHLTC where there is a reasonable suspicion that abuse or neglect occurred or may occur" rather than "a person" as stated in s. 24(1); and
iii) that "a report must be submitted to the MOHLTC within 10 days" rather than to immediately report the suspicion and the information upon which it is based to the Director.

B) Review of the home's "Abuse and Neglect Prevention" policy number NUR-FM-02-01 revised March 15, 2016, indicated the following regarding certain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents:

i) that investigation of allegations of abuse should begin "within one business day", rather than immediately according to s.23(1).

During interview, the DOC confirmed that the home's "Abuse and Neglect Prevention" policy did not comply with legislative requirements in terms of investigating and reporting alleged, suspected or witnessed abuse and neglect of residents. [s. 20. (2)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an incident of abuse was immediately investigated and reported to the Director.

A) On a specified day in 2016, resident #018 sustained two injuries as a result of being physically held by staff member #120. The resident's plan of care directed staff to allow flexibility in ADL routine and to leave and return later to gently try again if resident became resistant. The PSW did not follow the plan of care and this resulted in harm to the resident.

The PSW reported the incident to RN #106, who directed the PSW to report it to the DRC. When the DRC became aware of the incident, an investigation was not initiated immediately. Instead, the PSW was directed by the DRC to not do this again and re-approach the resident next time. The incident was confirmed by the PSW and DRC. The DRC confirmed they did not initiate an immediate investigation or submit a critical incident to the Director. (169)

B) On a specified day in 2016, resident #013 and #014 reported to LTC Inspector that they had been told by nursing staff on night shift to “behave" and not to ring the call bell. Although they could not remember details about these incidents, resident #013 reported that this made them feel upset. Upon learning this, the LTC Inspector reported to DRC that the resident had complained that night staff had told them not to ring the call bell and that this made them feel upset.

During interview several days after initially bringing these concerns to the DRC, the DRC stated that they spoke with resident #013 about continence care, however resident #013 and #014 stated that the DRC had not addressed this issue with them. Review of progress notes revealed that the ADRC followed up with resident #013 as directed by the DRC several days later, pertaining to care concerns during the night (and not about staff being rude and telling the resident not to use the call bell). The ADRC confirmed this. During interview resident #013 and their roommate #014 stated that they did not feel that this issue had been resolved. (526) [s. 23. (1) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure advice of the Residents' Council was sought out in developing and carrying out the satisfaction survey, and in acting on its results.

Review of the home's Residents' Council meeting minutes, interview with the President of the Residents' Council, and interview with the Assistant to the Council confirmed that the home did not seek the advice of the Council in developing and carrying out the home's annual satisfaction survey or in acting on its results. [s. 85. (3)]

2. The licensee failed to ensure the results of the satisfaction survey were made available to the Residents' Council in order to seek the advice of the Council about the survey.

Review of the home's Residents' Council meeting minutes, interview with the President of the Council, and interview with the Assistant to the Council confirmed that the home did not ensure the results of the home's annual satisfaction survey was shared with the Council in order to seek advice of the Council about the survey. [s. 85. (4) (a)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan,

policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

A) The home's "Medication Administration" policy number CNS-00-06-04, last revised February 22, 2016, directed staff to "observe the resident taking all of the medications with water provided and never leave medication at side of bed, on table in dining room, at resident's side and always ensure they take the medication".

On a specified day in 2016, at approximately 0830 hours, LTC Inspectors observed resident #051 with medications located in a medication cup on the breakfast table beside their plate; registered staff were not in view of the resident. When interviewed, RN #106 stated that the resident must have brought the medications to the dining room from their room. The RN confirmed that they would frequently leave the medications with the resident to self-administer and that the resident did not have a physician's order to self-administer medications.

At approximately 0840, the resident was observed putting the medications in their mouth, at which time a white pill dropped down into their clothing and onto the floor. A dietary aid was assisting the resident and stepped on the pill causing it to be carried about two metres away from the resident. About five staff including two registered staff walked by the medication on the floor and RN #106 did not check to see if the resident had taken their medications. At about 0850, the LTC inspector informed RN #106 that the resident had dropped the medication. The RN picked it up, confirmed that they hadn't noticed that the resident had dropped the medication and had not observed the resident taking the medication. They also confirmed that this was a medication error since they had not observed the resident taking their medication causing the medication to drop and that it had to be replaced with the same medication from another day.

During interview, the ADRC confirmed that staff RN #106 had not followed the home's policy or the home's expectations that the resident be observed while taking their medications, and that the staff RN had not completed an incident report when the medication was spoiled. (526)

B) The home's "Medication Disposal" policy number 5.8 revised July, 2014 directed staff in the destruction and disposal of medications. The policy directed staff as follows: "Drugs designated for disposal are placed in a designated one-way Medismart drug destruction container provided", and "The sealed designated drug destruction container is stored safely and securely in the Home, accessible only to registered personnel, until a

medical waste company picks up the destroyed medication".

On May 24, 2016, the ADRC reported to the LTC Inspector that once regular and controlled medications were destroyed, they would place the one way drug destruction container in the basement in a "Sump Room" and it would stay there until the waste management company came to pick it up approximately every two months. The ADRC confirmed that the storage area was accessible to staff other than registered personnel since maintenance staff had access to the storage area as well. The ADRC confirmed that this storage practice did not comply with the home's "Medication Disposal" policy. (526)

C) The home's "Administering Routine Medications" policy number 4.2, last revised November, 2015, directed staff as follows: "Each individual medication is initialed as administered, on the MAR/TAR sheet in the correct boxes (date/time), upon administration and before administering the next resident's medication(s)".

According to progress notes, resident #049 was administered medication on two occasions where the resident's electronic medical administration record (eMAR), had not been signed to indicate that these medications had been administered according to the home's policy. During interview, the DRC stated that it was an expectation that all medications were to be signed by the nurse after they were administered to the resident. During interview, the DRC confirmed that the home's policy had not been complied with when staff failed to indicate in the eMAR that resident #049 received the medication. (649)

D) According to interview with the home's ADRC and DRC, and review of the home's Medication Management System registered staff were required to complete a "Resident's Individual Narcotic and Controlled Drug Count Sheet" at the time of administration for each controlled substance administered to each resident. The home's expectations also required oncoming and outgoing registered staff to count controlled substances located in the controlled substance storage area during shift change and to indicate the count of each resident's controlled substance medication on the home's "Narcotic Ward Count" sheet.

During inspection of the home's medication management system conducted at approximately 1030 hours on May 24, 2016, LTC Inspector observed that registered staff #115, #106 had failed to sign the home's "Resident's Individual Narcotic and Controlled Drug Count Sheet" and "Narcotic Ward Count" for controlled substances administered to

residents in the home. The registered staff confirmed this. In addition, three count sheets on the first floor had outgoing signatures for counts that had not yet occurred for the 1450 hours shift change count; this was confirmed by RPN #114.

During interview, the ADRC and DRC confirmed that staff had not followed the home's policy on documentation of controlled substance administration on the "Resident's Individual Narcotic and Controlled Drug Count Sheet" on May 24, 2016, and shift change counts on the "Narcotic Ward Count" sheets on May 23 and 24, 2016. (526)

E) The home's "Pain Assessment & Treatment" policy number CNS-00-15-01, last revised May 19, 2016, directed staff to complete pain assessments every week on Saturday for identified residents. Resident #015 fit the criteria for pain assessment. During a three month time period, review of the resident's health record identified that the resident only received seven out of twelve weekly pain assessments. The DRC confirmed the home's pain policy was not complied with since the resident had not received weekly pain assessments. (586)

F) According to the home's policy titled "Pain Assessment and Treatment" (policy # CNS-00-15-01, last revised May 19, 2016) stated, pain assessment was to be completed on specified residents. Resident #049's health record indicated that resident met these criteria during a two week time period in 2016, after returning from hospital, during which time, their pain was not assessed according to the home's policy. During interview, the DRC confirmed that the home's policy was not followed as a weekly pain assessment should have been initiated immediately upon return from hospital.

G) According to the home's "Clinical Assessments" (policy number 60.16.10S, last revised 16/08/2013) stated, that a resident should receive a pain assessment upon return from hospital. A review of resident #049's health record indicated that upon return from the hospital on a specified day in 2015 no pain assessment was completed until three days later. During interview, the DRC confirmed that the home's policy had not been complied with. (649)

H) The policy named "Temperatures of Hot Food-Dietary" GM-01-06, revised February 2, 2016 directed staff to ensure that hot foods were not held for any length of time at temperatures less than 60 degrees Celsius or 140 degrees Fahrenheit. On June 1, 2016 during observation of the dinner meal on first floor, the temperature of the pureed entree of meat was probed by the dietary aide at 1745 hours at 50 degrees Celsius. The food in the servery was being held at temperatures less than 60 degrees Celsius, according to

the policy. This was confirmed by the Food Service Supervisor. (169)

I) The licensee failed to ensure that the home's "Resident Call Bell System" policy number CNS-0007-01 was complied with. The policy was last revised on May 6, 2016 and directed staff to use their pagers to manage the resident call bell system. Observation throughout the entire home confirmed there were no pagers used in the home. The PSW's on first and second floor home areas and DRC confirmed there were no pagers available with the call bell system. (169)

J) The home's "Minimal Lifts" policy number CNS-FM-07-01B, last reviewed on November 6, 2015, stated that "Staff are provided at minimum annual education about the safe use of, inspection of mechanical lifts" as established by the organization. Interview with the DOC confirmed that all staff were to receive safe lifts and transfers training on an annual basis. In an interview with the Education Coordinator, they confirmed to LTC Inspectors #526 and #169 that the Faith Manor staff were not receiving safe lifts and transfers training annually. (586)

K) The licensee failed to ensure that the policy named "Personal Assistive Services Devices" (PASD) revised March 16, 2016 was complied with.

The policy directed staff to include in the mandatory documentation the following: PASD assessment request and prescription by whom, occupational therapist (OT) or physiotherapist (PT), date and rational, consent obtained. Resident #018 was observed with two assist rails on their bed, in the guard position at the head of the bed. The plan of care identified the rails were used to assist the resident with activities of daily living, however the plan of care did not include a prescription by and OT or PT and consent including the date and the rational for use of the bed rails. This was confirmed by the lack of documentation and the DOC. (169) [s. 8. (1) (b)]

Additional Required Actions:

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

WN #7: 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 prevailing practices to minimize risk to the resident.

According to prevailing practices tilted "Clinical Guidance 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 adopted by Health Canada), all residents who use one or more bed rails were to be evaluated by an interdisciplinary team, over a period of time while in bed to determine safety risks associated with bed rail use. To guide the assessor, a series of questions would be completed to determine whether the bed rail(s) were a safe device for residents while fully awake or while they were asleep. The guideline also emphasized the need to document clearly whether alternative interventions were trialled before bed rails were implemented and if the interventions were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, cognition, behaviours, medication use, mobility and any involuntary movements, falls risks, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed), environmental factors and the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or their Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device).

The final conclusion would be documented as to why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many,

on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified in the above guideline. According to the licensee's policy titled "Bed Rails" date February 5, 2016, a questionnaire was to be completed by the Registered Nurse (RN) titled "Bed System Assessment" on their computer system for each resident. Verification was made that the "Bed System Assessment" was completed for all residents, however the questions and processes identified in the prevailing practices identified above were not fully included. The licensee's policy identified that at the conclusion of the assessment, the nurse would "determine, based on the assessment, whether the bed rail was a restraint or a PASD (Personal Assistance Services Device)". No reference was made in the policy regarding a conclusion of potential risk and how to ensure that the bed rail was safe for the resident in their assessed condition. The only reference made to bed safety hazards in the policy fell under section (c) directing the RN to discuss with the resident or their SDM the risks associated with the bed rails.

Review of the home’s bed entrapment audit conducted during June and July, 2015, included the completion of the “Bed System Inspection Form” for each bed system. The audit revealed that seven beds failed zones of entrapment for residents #003, #165, #011, #013, #014, #166, and #167; some of these bed systems involved the use of air mattresses.

Review of the health records for the residents residing in these beds revealed that they had not been assessed in these bed systems to minimize their risk of entrapment according to best practice as discussed above. The DRC confirmed that the PASD assessment instrument did not address best practices as mentioned above, and these residents had not been assessed to minimize their risk for entrapment. [s. 15. (1) (a)]

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

Review of the home’s bed entrapment audit conducted during June and July, 2015, included the completion of the “Bed System Inspection Form” for each bed system. The audit revealed that seven beds failed zones of entrapment. The residents who resided in these beds were observed on June 1, 2016, laying in the beds with the bed rails causing failed zones of entrapment in the raised position. During this observation, no bed

accessories were observed on or around the elevated bed rails and confirmation was made by the bed safety lead involved in assessing the residents that no accessories had been implemented.

According to the "Bed Safety Assessment", section #3, beds with therapeutic air mattresses were not tested for zones of entrapment and therefore section 3B was not completed to determine what actions or steps were necessary to reduce or mitigate the zones of entrapment. Discussion was held with the bed safety lead that the questionnaire needed revisions and that all residents using a therapeutic air mattress would require safety interventions as the beds typically fail one or more entrapment zones due to their soft design. Preventative steps were therefore not taken to mitigate the zones of entrapment for residents #003, #165, #011, #166, #013, #014, and #167 who were residing in beds with and without air mattresses that failed zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

Review of resident #015's health record and interviews with PSWs #119, #111 and #121 confirmed that staff would either use the full mechanical lift or the sit-to-stand lift to transfer the resident, depending on what was available at the time. This was confirmed during interview with the resident.

Review of the resident's most recent Transfer Ability Assessment indicated that the resident required the use of a specified transfer device and was unable to use another device available to staff to transfer residents. This was confirmed in their most recent Significant Change in Status Assessment and in their plan of care.

Interview with the Occupational Therapist (OT) confirmed that they witnessed PSWs transferring the resident to bed using the lift that the resident was identified as unable to use. Interview with the Physiotherapy Assistant (PTA) confirmed that the staff should not use the lifting device with resident #015 and said it was "not safe". The staff did not use safe transferring devices when assisting resident #015. [s. 36.]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed, and that where the condition or circumstances of the resident required, a post fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

A) Review of resident #049's health records indicated that on a specified day in 2016, they lost their balance and fell, causing injury. They required staff assistance to ambulate and a post-fall assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for falls at that time. They were admitted to hospital the following day and required treatment. According to their health record no post-fall assessment was conducted using a clinically appropriate assessment instrument immediately after the fall or at any time thereafter before they were sent to the hospital.

During interview, the DRC stated that it was the home's expectation that the staff conduct a post-fall assessment prior to moving the resident after a fall, and confirmed that resident #049 was not assessed using a clinically appropriate assessment instrument that was specifically designed for falls, between the time of their fall and their hospitalization.

B) After returning from hospital, resident #049 had another fall with no injury. Review of their health record revealed that no post fall assessment was conducted at that time.

C) According to health records, resident #049 had a fall on a specified day in 2015 and were noted to have difficulty moving an extremity. A review of their health records revealed that no post fall assessment was completed after the fall. Several days later the extremity's condition had deteriorated and was noticeably injured. The resident was hospitalized at which time they received treatment. A review of the health record indicated that a post-fall assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for falls between the time of the fall and their admission to hospital.

During interview, the DRC confirmed that staff failed to conduct a post-fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls after resident #049 fell on three separate occasions in 2015, and that this may have contributed to a delay in the resident receiving the necessary treatment and pain management. [s. 49. (2)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

According to their health record, on a specified day in 2016, resident #013 had developed an area of altered skin integrity and was prescribed a daily treatment. During interview, resident #013 complained to LTC Inspector that they had pain related to skin and wound, and transferring and positioning issues. Progress notes and interview with the ADRC indicated that the resident's altered skin integrity had worsened since initially identified.

Review of their health record and interview with ADRC revealed that staff had not

conducted a pain assessment using a clinically appropriate assessment instrument over a 25 day period in 2016, according to the home’s expectations when a resident had an area of altered skin integrity. Interventions to manage the resident's pain had not been initiated. In addition, their plan of care had not been updated when the resident developed the alteration of skin integrity. The ADRC confirmed that the plan of care should have been updated. The ADRC confirmed that resident #013 had not received interventions to reduce or relieve pain, promote healing, and prevent infection, as required. [s. 50. (2) (b) (ii)]

2. The licensee failed to ensure that, when a resident exhibited altered skin integrity, including skin tears, they were reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

A) Resident #003 had a chronic area of altered skin integrity. A review of the past three months clinical notes revealed that as the condition of the area worsened, 7 out of 12 reassessments were not completed. The Registered Nurse (RN) #106 confirmed the weekly wound reassessments, which were to be completed on Saturdays, were not consistently completed and that the area of altered skin integrity worsened.

B) The licensee failed to ensure that when resident #018 exhibited an area of altered skin integrity, that it was reassessed at least weekly by a member of the registered nursing staff. According to health records, resident #018 sustained an area of altered skin integrity on a specified day in 2016 that worsened and required treatment. The area was not reassessed until 12 days after the assessment that identified the skin condition had worsened. This was confirmed by the RN #106 and clinical documentation.

C) According to their health record, on a specified day in 2016, resident #013 was noted to have developed an area of altered skin integrity and was prescribed a daily treatment. During interview, resident #013 complained to LTC Inspector that they had pain related to skin and wound, and transferring and positioning issues. Progress notes and interview with the ADRC indicated that the resident's altered skin integrity had worsened over the next 25 day time period.

Review of health records indicated that an intial skin and wound assessment was not completed when the area of altered skin integrity was observed, and a reassessment was completed by a registered staff one time during the next 25 day period. In addition, no head to toe skin assessments had been completed by non registered staff on the resident's bath day according to the home’s expectations during that time.

Progress notes and interview with the ADRC indicated that the resident's area of altered skin integrity had worsened after 25 days. During interview, the ADRC confirmed that resident #013's altered skin integrity had not been assessed initially or weekly by a member of the registered nursing staff when clinically indicated, that PSW staff had not documented the status of the resident's skin during that time, and that the resident's skin integrity had deteriorated over a 25 day period in 2016. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment.

A) Resident #041's most recent RAI MDS assessment completed in 2016, indicated that they were incontinent and required total assistance from two staff for transferring; this was confirmed by PSWs #102, #103 and RN #101. The resident's most recent continence assessment outlined the care provided to the resident. Resident #041 complained to the LTC Inspector that, on a specified day in 2016, PSW #100 did not toilet them, causing them to become incontinent, or provide hygiene care as usual, and stated feeling upset about this since they might develop complications as the result of care not being provided. The resident also stated that there had been times when staff would not attend to or delayed attending to them for over 20 to 30 minutes if they needed to use the toilet. They confirmed that their family member would transfer them to the toilet

because the staff were not always available. During the course of this inspection, LTC inspector observed resident #041's family requesting assistance with toileting and PSW staff responded that the resident was not "their resident" and did not assist.

PSWs #100 and #111 who were caring for resident #041 on the specified day in 2016, confirmed the resident's accounts as noted above. PSW's #102, #103, and #104 described different information about the resident's toileting preferences which was also different from the description provided by RN #106 and the DRC.

During interview, ADRC and DRC confirmed that resident #041's continence plan of care was not individualized based on an assessment, or implemented to promote and manage bladder continence.

B) Review of resident #041's health record and resident interviews indicated that they were at risk for developing a health condition that required treatment. During interview, the resident stated that they were exhibiting symptoms of the health condition and expressed concerns when they had not received care to prevent the health condition.

During interview, RN #106 confirmed that the resident was at risk for the specified health condition. They stated not knowing that the resident had symptoms and thought that these symptoms were a regular behaviour for them, but could also indicate the presence of the health condition that they were at risk for developing. The RN and the DRC confirmed that an individualized plan of care had not been developed to monitor the resident's risk for the health condition as a way to promote and manage bladder continence for resident #041.

C) According to their health record, resident #014 was at high risk for falls and had mobility limitations so that they required the use of a wheelchair. Health records indicated that they were frequently incontinent and specified that two staff were needed for toileting, supervision and safety. This was confirmed by the physiotherapy assistant (PTA) staff #110, and PSWs #103 and #124. The PTA and PSWs confirmed that the resident became impatient waiting for assistance with toileting and would risk their safety by self-transferring. The PSWs also stated that almost always, the resident would transfer themselves to the toilet and ring the call bell for help to transfer from toilet to their wheelchair.

During interview, PSWs #110 and #124, the DRC, and ADRC confirmed that resident #014's plan of care was not implemented when the resident would wait for assistance

and then toilet themselves, instead of two staff persons assisting them. They confirmed that the resident's risk for falls was increased when the plan of care to promote and manage bladder continence was not implemented. [s. 51. (2) (b)]

Additional Required Actions:

CO # - 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) According to health records and interviews with resident #041, they had experienced pain during the previous six months. Review of their eMAR indicated that they received pain medication as needed almost daily over the past six months in addition to regularly scheduled pain medication.

Review of their health record indicated that their pain had not been assessed using a clinically appropriate assessment instrument specifically designed for this purpose for at least one year from the time of this inspection. During interview, the DRC confirmed that resident #041's pain should have been assessed using clinically appropriate assessment instrument specifically designed for this purpose since their pain had not been relieved by initial interventions. (649)

B) Pain assessments had not been completed for resident #049 as follows, when initial interventions had not been effective:

i) Resident #049 fell on a specified day in 2015. According to progress notes, the resident showed signs of injury and pain. During interview, the DRC confirmed that no pain assessment was completed at this time.

ii) According to progress notes, hours after resident #049 had fallen, they showed signs of severe pain, were administered medication that was not effective in alleviating the pain. They were transferred to the hospital where they received treatment for the injury. A review of the health records indicated that their pain had not been assessed using a clinically appropriate assessment instrument specifically designed for this purpose when initial pain management interventions were not effective before they were transferred to hospital.

iii) Resident #049 fell on a different day in 2015 and several days later, an extremity was noted to be injured. They were transferred to hospital where they received treatment for the injury sustained and returned to the home several days later. Review of health records indicated that a pain assessment was not completed upon return from hospital after surgery until several days later. The resident was not administered pain medication as ordered and progress notes indicated that they were experiencing pain. Staff failed to document the administration of the medication according to the home's policy and no pain assessments were found when initial interventions were not effective in alleviating the resident's pain.

The DRC confirmed that resident #049's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose after their fall and then not again after return from hospital for several days when their pain was not relieved by initial interventions. The DRC further stated that the home's policy for pain assessment was not followed during this time. (649)

C) During interview, resident #019 complained to LTC Inspector that they were having pain. Review of their health records indicated that they had complained of pain six times during a three day period and could not sleep due to pain during a 10 day period in 2016. Medication administered during these time periods was noted as being ineffective.

Review of their health record indicated that they had not had a pain assessment using a clinically appropriate instrument specifically designed to assess pain over a four month time period that covered the incidents noted above.

During interview, the RAI Coordinator was asked about notifications to staff that informed them when a pain assessment was overdue for resident #019. They stated that this flag was usually ignored and cleared. The DRC confirmed that resident #019's pain over a two month time period in 2016 should have been assessed using a clinically appropriate assessment instrument specifically designed for this purpose when their pain had not been relieved by initial interventions. (526) [s. 52. (2)]

Additional Required Actions:

CO # - 012 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that direct care staff were provided training in pain management, including recognition of specific and non-specific signs of pain.

In accordance with paragraph 6 of subsection 76(7) of the Act, review of the home's mandatory training records for all direct care staff revealed that only registered staff had received training for the home's pain management programme during 2015. During interview the home's staff educator confirmed that non registered staff who also provided direct care to residents had not received mandatory training for pain management in 2015 and had not been offered training in 2016 as of the time of this inspection. During interview the DRC confirmed that not all direct care staff had received training for the home's pain management programme in 2015. [s. 221. (1) 4.]

Additional Required Actions:

CO # - 013 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #14: 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).

Findings/Faits saillants :

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

A) Residents #013 and #014 lived in the same room. During interview with the LTC Inspector, the following incidents occurred on specified days during 2016:

i) PSW #121 entered the closed door without knocking to turn off the call bell; provided care to resident #013 and left the room;
ii) PSW #121 entered the closed door to their room without knocking, interrupted the interview and stayed while LTC inspector tried to complete the interview;
iii) PSW #122 entered the closed door to their room without knocking, interrupted the interview and stayed for approximately two minutes, left the room with the door ajar saying that they weren't finished, entered the room again, and then left closing the door.

When resident #014 was asked if staff entered the room without knocking, they stated that their room was their home and reported that staff frequently did not knock prior to entering their room. During interview, PSW #103 stated that usually the residents' door was opened and they didn't have to knock; they confirmed that they should have knocked before entering to respect the resident's privacy and their personal needs.

B) On a specified day in 2016, resident #011 was observed from the hallway, through the doorway to their room receiving care from two PSWs as two registered staff entered their

room with the treatment cart. The resident was observed in their bed being turned away from the door; the privacy curtain had not been pulled around them. Approximately five minutes later, LTC Inspector returned to the door that was approximately six inches ajar and observed four staff in the room and could view the resident receiving care. During interview, PSW #123 who was caring for the resident stated that they thought that the privacy curtain had been closed, was not aware that it was open, and confirmed that it should always be closed.

During interview, the DRC and ADRC confirmed that staff should knock prior to entering rooms and also ensured that they had privacy during care. They confirmed that the home had not protected and promoted resident's #013, #014, and #011 right to be afforded privacy in treatment and in caring for his or her personal needs.

C) The licensee failed to ensure that resident #160 was provided privacy while going to the washroom. On a specified day in 2016, the resident was observed sitting on the toilet, with their pants down and the door open approximately 12 inches. The resident's naked bottom and legs were fully visible to any one walking by in the shared room. The resident confirmed the staff do this practice all the time and leave the door open. (169)

D) The licensee failed to ensure that resident #054 was afforded privacy in caring for their personal needs. On a specified day in 2016, resident #054 was observed sitting in their wheelchair in the hallway, outside the shower room. The resident was crying and was distressed. Staff member #120 was observed walking by and telling the resident they would get into the shower in a few more minutes. The resident responded by stating they had been waiting a long time already. Ten minutes went by and the same staff member was observed walking by and telling the resident they would again, get into the shower in a few more minutes.

After their shower, the resident was interviewed and identified they were very upset about sitting in the hallway without proper covering on. The resident identified they were awoken by the staff member #120 very early and then were made to wait for a long time before going to the shower. Staff member #120 confirmed the resident was waiting for about ten minutes for their shower and was only wearing a housecoat, with their brief sitting on their lap. The resident was not treated with respect and provided privacy while waiting for their shower. (169) [s. 3. (1) 8.]

Additional Required Actions:

CO # - 014 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) On a specified day in 2016, resident #003 was prescribed a topical medication. The medication sheets identified the medication was not provided as prescribed. However, interview with the RN #106 revealed the medication was applied but the administration was not documented. This was confirmed by clinical documentation and the RN. (649)

B) According to health records resident #049's front facing lap belt restraint was to be monitored hourly beginning on a specified day in 2015. Review of the home's "Restraint Form" indicated that staff had not documented that "Hourly Check of Restraint Status and Positioning Change" had not been completed during the evening shift for at least an entire month in 2015. During interview, the DRC stated that staff conducting hourly checks of resident #049's restraint and implementation of their plan of care to monitor the resident who had a restraint, could not be verified; they confirmed that the hourly checks had not been documented as indicated above. (649) [s. 30. (2)]

Additional Required Actions:

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

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident was restrained by a physical device as described in paragraph 3 of subsection 30(1) if the restraining of the resident was included in the resident's plan of care.

Resident #041 had a health condition where a lap belt was applied to prevent injury when the resident was not able to control their bodily movements. RN #106 confirmed this during interview. The resident was unable to release the lap belt during these episodes as confirmed by the RN, the resident and their family member.

Review of the resident's health record revealed that the resident had not been assessed for the use of the lap belt as a restraint and was not included in their plan of care. This was confirmed by RN #106, who also stated that they observed the lap belt restraining the resident but were not sure if it should be applied for resident #041 as it may pose a risk. During interview, the PT stated that while resident #041 had received PT services, they had not been assessed for the use of a lap belt. RN #106 confirmed that resident #041's lap belt acted as a restraint, but that it was not included in their plan of care. [s. 31. (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 resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's "Resident Call Bell System" policy number CNS-00-07-01 last reviewed on May 6, 2016, indicated that "the call bell system must be easily seen, accessed and used by residents, staff and visitors at all times" and "a functioning call bell must always be within reach of the resident".

During this inspection, resident #013 reported to the LTC Inspector that they experienced pain due to their health condition, related to transferring and positioning, and an area of altered skin integrity. They stated that they would use the call bell to ask for help but that staff had discouraged them from using it. The document the home referred to as their care plan directed staff to ensure that the call bell was within reach and to encourage them to use it.

On a specified day in 2016, the LTC inspector observed PSW #121 providing care to resident #013 and then left the room. When asked to trigger the call bell, the resident said that they would if they could find it and that was a frequent problem for them. They were observed being unable to reach and activate their call bell. The LTC Inspector observed the call bell lying on the floor underneath resident #013's bed. The resident stated that their voice was quiet and they would not be heard if they tried to call and also couldn't reach their phone if they wanted to call the nursing station. They stated being worried that no one would know that they needed help.

During interview, PSW #121 confirmed that resident #013's call bell should be accessible at all times and that it was not easily seen or accessible for use by the resident given that it was on the floor beneath their bed. During interview the DRC and ADRC confirmed that a resident would not be able to access their call bell if it was located on the floor under their bed, and that staff should ensure that residents have access to their call bell prior to leaving the room. [s. 17. (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 the home is equipped with a resident-staff communication and response system that (a) can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when restraining a resident by a physical device under section 31 or 36 of the Act, that staff applied the physical device in accordance with manufacturer's instructions.

The home's "Safety Device –Use Of" policy and procedure [no number or revision date] indicated that "A seat belt attached to a wheelchair, with safety buckle, which a resident can undo" was a safety device. Staff were directed that "any belt should be not too loose to allow a client to slide under the belt, nor too tight to irritate bony prominences or soft tissue; the two finger rule".

A) Resident #050's plan of care and interview with RPN #105 indicated that the resident was restrained by a lap belt while sitting in a wheelchair. During this inspection, the resident was observed by the LTC Inspector to be sitting in their wheelchair with their lap belt applied loosely, approximately four finger widths, from their torso. During interview, RPN #105 confirmed that the lap belt was loose and not applied according to manufacturer's instructions, and tightened it to two finger widths from the resident's torso.

B) Resident #041 had a health condition where a lap belt was applied to prevent injury when the resident was not able to control their bodily movements. During interview, RN #106 confirmed that the resident used a lap belt for their safety and that the resident would not be able to release the lap belt. They stated that they had observed the lap belt restraining the resident from sliding down, and confirmed that there was a risk if their lap belt was applied too loosely.

During this inspection, resident #041 was observed sitting in their wheelchair with a lap belt applied loosely, approximately four finger widths, from their torso. The resident told the inspector that they liked to have the belt applied for safety to prevent them from sliding down their chair if they were to lose control of their body movements. They stated that the belt was too loose during the observation. During interview, Registered Nurse #101 confirmed that the lap belt was loose and tightened it to two finger widths from their torso.

During interview, the ADRC confirmed that lap belts as safety devices should be applied to within 2 finger widths of a resident's torso according to manufacturer's instructions, and that the lap belts for resident #050 and #041 had not been applied according to the manufacturer's instructions. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the program included the development, implementation and communication to all residents and families of a schedule of recreation and social activities that were offered during days, evenings and weekend.

On June 1, 2016 during an evening inspection, it was observed that an activity calendar was not posted for viewing by anyone on the first floor. The residents were asking what activity was scheduled for the evening and were unable to locate any information about it. The recreation staff were interviewed and confirmed there wasn't a calendar posted today, June 1, 2016, however the staff member was in the process of creating and printing the June calendar. A review of the previous activity calendars for the past six months was completed and it was noted there were no activities offered in the evenings Monday through Friday, consistently. This was confirmed by the documentation and the interview with recreation staff. [s. 65. (2) (b)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all food was prepared and served using methods which preserve taste, nutritive value, appearance and food quality.

A) The pureed menu for June 1, 2016 dinner meal consisted of pureed beef stew, rice pilaf and brussel sprouts; there was no mention of the use of gravy. Observation of the dinner meal service on June 1 2016, in the second floor dining room, revealed that the entire pureed entree was covered in gravy and served to the residents. Inspector #586 interviewed the Dietary Manager (DM) who confirmed that gravy should not have been served on the food items, and confirmed this affected the taste and appearance of the resident dinner meal. (640)

B) During dinner meal service on June 1, 2016, in the second floor dining room, four PSWs, one volunteer, one RN and one RPN were observed to be mixing pureed foods, spoon by spoon, for all residents requiring assistance with eating. The pureed food items being mixed were the beef stew, rice pilaf and brussel sprouts along with the gravy. Inspector #586 interviewed the DM who confirmed that food items should not be mixed when assisting residents with feeding, unless indicated in the resident's plan of care, and that this would not preserve the taste of the food. (640)

C) On June 1, 2016, during the dinner meal on first floor a PSW heated a chicken wrap and mixed bean salad in the public microwave for a resident. The PSW asked the dietary aide about heating it and the dietary aide directed the PSW to heat it in the public microwave. The PSW was observed heating the food for two minutes. The home did not have a policy to direct the staff on how long to heat items, nor did the PSW have a thermometer available to use. The appearance of the food, after microwaving, appeared dry and hard and extremely hot, with a significant amount of steam. The food was served to the resident without regard to the appearance or food quality. This was confirmed by the Dietary Manager. (169) [s. 72. (3) (a)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

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

Findings/Faits saillants :

1. The licensee failed to ensure food and fluids being served to residents were served at temperatures that were palatable to the residents.

A) During the course of this inspection, the following was observed during a breakfast meal service:
i) Yogurt was observed on each place setting at 0815 hours, and pre-poured drinks were distributed at 0820 hours.
ii) At 0830 hours, 14 place settings had yogurt and drinks set out with no residents in the assigned seats. There were also five room service trays prepared with yogurt, milk, juice and water.
iii) At 0840 hours, 10 place settings were still unoccupied, and at 0850 hours, three place settings were unoccupied.
iv) At 0900 hours, residents #002 and #055 came into the dining room and ate food items which had been sitting out for 40 minutes.

v) At 0910 hours, food items that were sitting at resident #008's place setting were put on a tray and taken to the resident in their room.
vi) At 0915 hours, the remaining five room service trays were sent to the resident rooms, containing food items that had been sitting out for 60 minutes.

Interview with the Dietary Manager confirmed that the food and drink items had been sitting unrefrigerated for an extended period of time, causing them to become unpalatable for the residents receiving the items.

B) The licensee failed to ensure that milk was served at a temperature that was palatable to residents. On June 1, 2016, during an observation of the meal service on first floor, it was observed milk was being pre-served to several residents, prior to them attending the meal. At 1646 hours, the dietary staff were observed putting milk on all tables. At 1705 hours, 10 residents had not arrived to their place setting, where there milk was pre-poured. At 1715 hours, three residents were interviewed to determine how palatable their milk tasted. Two of the three residents identified it was warm and did not taste very good, however this was how it was always served. One of the three residents identified the milk tasted fine. The Dietary Manager confirmed the milk had been pre-poured resulting in a decreased palatability for two residents. It was noted these two residents did not drink their milk during the meal. [s. 73. (1) 6.]

2. The licensee failed to ensure that meals were served course by course, unless otherwise indicated by the resident or the resident's assessed needs.

During dinner meal service on the second floor on June 1, 2016, six of 12 tables were observed to have multiple courses of food served to residents at one time. Inspector #586 interviewed the Dietary Manager who confirmed the meal was to be served course by course. [s. 73. (1) 8.]

3. The licensee failed to ensure that proper techniques, including safe positioning, were used to assist residents with eating.

A) Resident #056's documented plan of care and Registered Dietitian (RD) assessment indicated that the resident required a texture modified diet. During the breakfast meal observation in a dining room, resident #056 was observed in their wheelchair in a reclined position while PSW #127 fed the resident. Interview with the PSW and the Dietary Manager confirmed all residents should be positioned at a 90 degree angle to ensure safe eating practices, and PSW #127 confirmed the resident was not positioned

appropriately.

B) The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance. During a supper meal observation, resident #056 was observed being fed a modified textured meal by a volunteer. The resident was leaning to the right side, while sitting in their wheelchair throughout the entire meal. The volunteer would move the residents head to the aligned position, each time a spoonful of food was provided. The plan of care did not direct the volunteer to do so. There was a PSW sitting at the same table, feeding two other residents and observed the poor positioning of resident #056. This was confirmed by the PSW and observation. [s. 73. (1) 10.]

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

A) Resident #057's most recent Minimum Data Set (MDS) Assessment indicated that they required total dependence on staff for eating. During a breakfast meal observation in a dining room, the resident was observed sleeping at the dining table with food placed in front of them. They were not assisted with eating until 35 minutes after the food and drinks were placed in front of them.

B) Resident #006's most recent MDS Assessment indicated that they required total dependence on staff for eating. During breakfast observation in a dining room, the resident was observed awake at the dining table with food placed in front of them. They were not assisted with eating until 23 minutes after the food and drinks were placed in front of them. [s. 73. (2) (b)]

WN #22: The Licensee has failed to comply with LTCHA, 2007, s. 84. s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee failed to ensure that the home had developed and implemented a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care services, programs and goods provided to residents.

The licensee was unable to provide written descriptions of the system that included its goals, objectives, policies, procedures and protocols and a process to identify programmes for review. The system was not interdisciplinary. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis. The licensee was unable to provide a record that set out the matters that any improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents and where they were communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis. The licensee was also unable to provide the names of the persons who participated in evaluations, and the dates improvements were implemented and the communication of all of the above. The lack of documentation confirmed a lack of a continuous quality improvement and utilization review system in the home. Interviews with the CEO and each department head also confirmed the lack of a quality improvement program. [s. 84.]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed implemented for cleaning of the home, including, i. resident bedrooms, including floors, carpets, furnishing, privacy curtains, contact surfaces and wall surfaces.

The ground level of the home had wall to wall carpeting in the hallways. The carpet was observed to be worn in the central walking area with several stains throughout the carpet. A discussion was held with a housekeeping staff who identified they were required to do spot cleaning of the carpet as needed on a daily basis. The same housekeeper also identified that they submitted a request to their supervisor to complete a deep cleaning of the carpet using a steam cleaner, as needed. Interview with the Supervisor of Housekeeping and the CEO revealed the steam cleaning occured approximately twice a month. Observation of the carpet on May 27, 2016 at 0800 hours, the morning after steam cleaning revealed the carpet was much cleaner, however some worn areas were evident. Observation on May 31, 2016 at 0900 hours revealed the carpet had several stains throughout the entire ground level. The procedure for cleaning the carpet did not allow for the carpet to be kept clean. It was noted the home would be undergoing a rebuild starting on October 2016 and the carpets would be replaced at that time. This was confirmed by the CEO. [s. 87. (2) (a)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

s. 101. (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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or staff member concerning the care of a resident or operation of the home:

• had been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and

• where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately

A) According to interviews with resident #041 and their family member, they complained to the DRC on a specified day in 2016, about care that was provided that day and about their dissatisfaction with PSW #100 who had provided care and was rude. The DRC confirmed that the family member had complained about care issues but stated that the family did not complain about a specific staff person. The DRC stated that the following day, they approached the resident, asked if they had any concerns about care that day, and when they said no, the DRC thought that there had not been an issue.

During interview one week later, resident #041 and their family member complained about the above incident and stated that it had not been resolved, that they had a concern about the care provided by PSW #100 and that they were rude, and that the DRC had not returned to them with a response.

The DRC confirmed that they did not fully investigate resident #041's family member's complaint when they asked a general question about care, did not initiate the investigation immediately when the complaint alleged harm or risk of harm to one or more residents, and did not provide a response to the complainant within 10 business days. The DRC confirmed that they did not retain investigation notes. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record of each written or verbal complaint (that had not been resolved within 24 hours) was kept in the home that included:

(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(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
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

A) During interview, the CEO reported that resident #041's family member came into their office almost daily since they began employment approximately six months ago. They stated that they had not maintained records of the resident's or their family

member's complaints and confirmed that not all verbal complaints were resolved within 24 hours.

B) During this inspection, resident #041 and their family member told LTC Inspector #526 that on a specified day in 2016, they reported to RN #101 that PSW #100 had spoken rudely to them and that staff wouldn't toilet them according to their needs. They also reported that they had complained to RN #106 and DRC approximately one week later, that PSW #100 had not provided care according to their needs. The LTC Inspector informed the DRC that the resident complained about PSW #100 being rude and disrespectful to them.

During interview, RN #101 stated that PSW #100 spoke loudly and the resident interpreted it as rude. The RN #106, RN #101 and DRC confirmed that they had not initiated an investigation of the resident's complaints and had not retained any notes of these complaints.

C) During this inspection, resident #013 reported to LTC Inspector that they had been told by nursing staff on night shift to "behave and not to ring the call bell". The LTC Inspector reported to DRC that the resident had complained that night staff had told them not to ring the call bell and that this made them feel upset. Approximately two weeks later, the resident reported to the LTC Inspector that the issue had not been resolved.

Approximately two weeks later, the DRC stated that they had asked the night nursing supervisor to "follow up and monitor", and directed the ADRC to interview the resident regarding their concerns about care. The DRC confirmed that they had not retained a documented record of complaints made by resident #013 according to legislative requirements.

D) During the Residents' Council meeting on March 21, 2016, resident #058 voiced concern about wait times for assistance with toileting. The minutes indicated that the issue would be forwarded to the DRC to investigate. In an interview with the resident, they indicated they did not receive follow-up from the DRC regarding this matter. The DRC informed the LTC Inspector that they did in fact follow-up with the resident, but was unaware of the exact date, and did not document any information about the meeting with the resident, including the type of action taken to resolve the complaint and the final resolution. [s. 101. (2)]

3. The licensee failed to ensure that (a) the documented record (of complaints received)

was reviewed and analyzed for trends, at least quarterly; (b) the results of the review and analysis were taken into account in determining what improvements were required in the home, and (c) a written record was kept of each review and of the improvements made in response.

During the course of this inspection, LTC Inspectors reviewed health records and the home's complaints binder. During interviews, the DRC and the home's CEO confirmed that not all complaints were documented and notes regarding complaints were not retained in their complaints binder. They confirmed that they had not evaluated the home's complaints management programme in 2015, and could not provide any documentation that indicated that complaints received had been reviewed and analyzed for trends quarterly or annually to determine improvements that could be made. [s. 101. (3)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On May 24, 2016, LTC Inspector observed that the controlled substances awaiting destruction were stored in a single locked stationary cupboard in a locked area. The ADRC confirmed that the cupboard had only one lock and confirmed that this did not meet legislative requirements. [s. 129. (1) (b)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

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

During the course of this inspection, the LTC Inspector observed topical medications in the rooms for residents #002, #003, #011, and #019. None of these residents had been authorized to self-administer these medications or to store them at their bedside. In addition, on May 20, 2016, unlocked topical medications were observed in a box on the counter of the nursing station throughout the shift. During interview, PSW #113, registered staff #114, and the ADRC confirmed that resident's topical medications should not be stored at residents' bedsides, or in the nursing station and should be kept locked at all times when not in use. [s. 130. 1.]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The home's "Administering Routine Medications" policy number 4.2, last revised November, 2015, directed staff as follows: "The medication(s) are administered to the Resident as ordered. Each individual medication is initialed as administered, on the MAR/TAR sheet in the correct boxes (date/time), upon administration and before administering the next resident's medication(s)".

According to their health record, resident #041 had multiple health issues. During the

course of this inspection, the resident had expressed concern that their medications were being administered late. According to interview with resident #041's substitute decision maker, on a specified day in 2016, the resident's 0800 hours medications were not administered until 1030 hours at the earliest. Review of the eMAR indicated that 11 medications scheduled to be administered to the resident at 0800 hours were signed off at 1217 hours.

The registered staff responsible for the administration of these medications was unavailable for interview. During interview, the DRC could not confirm that the medications were given as specified by the prescriber and that it was concerning that the resident's family member stated that the medications were administered late. In addition, the DRC stated that the medications were not signed for when the medications were given. [s. 131. (2)]

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

During the course of this inspection, resident #011 was observed to have a medication located at their bedside that was to be administered four times daily. During interview the resident stated that they didn't know exactly what the medication was for and described how they administered it.

Review of their health record indicated that the self-administration of the medication had not been approved by the prescriber in consultation with the resident and this was confirmed by RN #106. During interview, the home's pharmacist stated that when a resident had been approved to self-administer a medication, the medication label would include this authorization; no indication of an approval was noted on the bottle for resident #011's medications. During interviews, the ADRC and RN #106 confirmed that resident #011 should not have self-administered a medication since they did not have the physician's order for them to do so. [s. 131. (5)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The home's "Reporting Medication Incidents" policy number 7.3 revised July 2014, directed staff to complete a "Classic Care Pharmacy Medication Incident Report" form, assess the resident, investigate the medication error, document and report the outcome of the investigation to the Director of Care, the Medical Director, the prescriber, the resident's attending physician or nurse in extended class and the resident's family. Once the investigation was complete, staff inform the pharmacy and a report is filed at the home for future review.

Review of resident #041's health record indicated that the resident visited with a family member away from the home and medications for administration would be sent with them. According to progress notes, on a specified day in 2016, the resident's family member called the home to complain that two pills instead of one pill for a prescribed medication were found in the packet provided for them to administer to the resident. The note also indicated that the resident reported receiving one of the pills as prescribed and that the family member had failed to bring the additional pill back to the home. No further

notes or follow up investigative reports could be located.

During interview, staff RN #117 stated that they had not completed an incident report at that time as they could not verify that a medication error had occurred. They stated that usually they would complete an incident report which would prompt the home's management to investigate, and would assess the resident's health status. During interview, the home's pharmacist confirmed that an incident report should have been completed, and that they had not been made aware of the incident by way of fax as was the usual practice.

During interview, the DRC confirmed that staff had not completed the "Classic Care Pharmacy Medication Incident Report" according to the home's policy, no investigation or notes had been initiated in response to the family members concerns and that relevant staff had not been notified according to the home's policy and legislative requirements. [s. 135. (1)]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents were communicated to the Residents' Council.

During review, the Resident Council meeting minutes did not include any documentation on the home's quality improvement and utilization review system. Interview by LTC Inspector #169 with the Assistant to the Council on June 7, 2016, confirmed that this information was not shared with the Residents' Council. [s. 228. 3.]

Issued on this 12th day of August, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	THERESA MCMILLAN (526), HEATHER PRESTON (640), JESSICA PALADINO (586), JULIEANN HING (649), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2016_265526_0010
Log No. / Registre no:	013027-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 19, 2016
Licensee / Titulaire de permis :	HOLLAND CHRISTIAN HOMES INC 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	FAITH MANOR NURSING HOME 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Amanda Quinlan

To HOLLAND CHRISTIAN HOMES 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)

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 :

The licensee shall do the following:

1. Provide the care set out in the plan of care to the residents as specified in the plan.

i. Resident #015 shall receive the care related to waking times according to their plan of care and preferences.
ii. Resident #018 shall receive the care related to resistive behaviour according to their plan of care.
iii. Resident #160 shall receive the care related to toileting/falls risk according to their plan of care.
iv. Resident #045 shall receive the care related to falls risk according to their plan of care, including wear appropriate footwear.
v. Resident #013 shall receive the care related to sleep and rest preferences according to their plan of care.

2. Implement a process to ensure that all staff are providing care according to each resident's plan of care.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual harm/risk
Scope: Isolated
Compliance history: This Non compliance was issued as a VPC on February 5, 2015; WN on January 7, 2015, and November 13, 2014.

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

A) During interviews with LTC Inspectors, resident #015 voiced concern about not being assisted out of bed and provided morning care according to their preference, causing them to be late for breakfast. The resident's documented plan of care indicated their preference. Interviews with PSWs #119 and #111 confirmed that they knew about the resident's preference, however, they were unable accommodate this due to the need to assist other residents first and due to the level of care resident #015 required. The staff confirmed the resident's sleep and rest plan of care was not provided to the resident as per their preference to meet their needs. The DRC confirmed care was not provided to the resident as per their plan of care. (586)

B) The licensee failed to ensure that the plan of care for resident #018 was provided as specified in the plan. On a specified day in 2016, the resident demonstrated resistive behaviour to care and the plan of care directed staff to leave the resident and then reapproach with a calm approach. PSW #120 did not follow the plan of care and insisted the resident receive the care, regardless of the verbal and then physical refusals by the resident. The incident resulted in a physical altercation between the resident and PSW #120, where the PSW grabbed the resident's hand, and resulted in the resident sustaining injuries during the altercation. This was confirmed by PSW #120, documentation and the DRC. (169)

C) The licensee has failed to ensure that resident #160 was provided the care as set out in the plan of care. On a specified day in 2016, the resident rang their call bell to go to the washroom. They were observed sitting on the toilet for over ten minutes alone in the washroom. The plan of care confirmed the resident required constant supervision while sitting on the toilet. A recent falls risk assessment confirmed the resident was high risk for falls. PSW caring for the resident on that day, confirmed the care was not provided to the resident, according to the plan of care. (169)

D) Resident #045 fell several times over a 12 month period. Their documented plan of care indicated that they were ambulatory, a high risk for falls and directed staff to implement falls prevention strategies.

The post falls analysis conducted after the resident fell on a specified day in 2016, indicated that one of the strategies that had not been implemented was a contributing factor in the resident's fall.

The resident was observed during the course of this inspection without the contributing falls prevention strategy being in place. Interview with Registered Practical Nurse (RPN) #105 confirmed that the strategy had not been implemented for several weeks. Only after this interview did staff begin to implement the falls prevention strategy. Interview with the BSO staff and DRC confirmed the resident should have had the contributing falls prevention strategy in place according to their plan of care in order to reduce their risk of falling. (586)

E) Resident interview and their written plan of care indicated that staff were to maintain predictable care routines for resident #031. On a specified day in 2016, the resident was observed waiting 25 minutes and 45 minutes to receive care. When asked if this had happened in the past, resident #013 and their roommate #014 told LTC inspector that staff would say something like "I'm late for my break", or “we are really busy right now”. When asked why they didn’t return right away to assist resident #013, PSW #121 told LTC Inspector that they had other resident’s to care for and didn't think to mention that there would be a delay in getting back to them. They confirmed that care was not provided according to resident #013’s plan of care by keeping them waiting for 20 and then 45 minutes before assisting them to get up without providing reassurance or an explanation about the delay. (526) [s. 6. (7)]
(586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 28, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall do the following:

1. Protect all residents from abuse by anyone and keep them free from neglect by the licensee or staff in the home by doing the following:

i) Implement a process to ensure that all staff are following the home's prevention of abuse and neglect policy;

ii) Immediately investigate, act upon, document, and report allegations of abuse to MOHLTC;

iii) Assess residents after having fallen using a clinically appropriate instrument specifically designed for post fall, pain, and skin and wound;

iv) Administer analgesia according to assessed needs;

iv) Refer residents to physician or RN in extended class according to residents' needs;

v) For residents exhibiting resistance to care, follow their plan of care to minimize responsive behaviours and risk for injury.

2. Re-train PSW's #100, #106, #111, #120, #126 and #132 on the home's abuse policy.

When re-training staff, the training program shall include the abuse policy, definitions of abuse including verbal, emotional and physical abuse, practical examples of abuse for learning purposes, Residents' Rights (including involving the SDM in care decisions when there is a change in a resident's condition), urinary tract infections, following the plan of care, team responsibilities, pain management, post-fall assessments, resistive behaviour/Gentle Persuasive Approach (GPA) training, clinical assessment of fractures, and documentation of timely clinical assessments.

4. Evaluate the home's prevention of abuse and neglect policy according to legislative requirements.

Grounds / Motifs :

1. Judgement Matrix:

Severity: Actual harm/risk
Scope: Isolated
Compliance History: This Non compliance was issued as a VPC on March 14, 2016; and as a WN on September 30, 2013.

2. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) During interview with resident #041 and their family member, the following was reported to the LTC Inspector throughout the course of this inspection:

i) The resident complained to RN #101 that PSW #100 spoke rudely and disrespectfully to them and that staff were not assisting them to toilet;
ii) The resident complained to the DRC and RN #106 that PSW #100 had not toileted them prior to being put back to bed and did not provide peri care during a brief change after being incontinent when they weren't toileted; the resident stated that they were afraid that they would develop an infection if they weren't clean;
iii) The resident complained to the LTC Inspector that PSW #100 was rude and disrespectful to them; this was reported to RN #106;
iv) The resident's family reported that they provided care since staff would not assist. The LTC inspector observed the resident's family asking for assistance and PSW #126 told them that resident #041 was not their resident and walked away;
v) The resident reported to the LTC inspector, that when PSW #100 saw the LTC inspectors in the home, they said to resident #041, something to the effect: "did you call the ministry to complain? If you did, you won't receive care". This statement could not be verified.
vi) The resident reported to the LTC inspector that the home did not have a zero tolerance of abuse, given the above concerns.

During interview RN #101, reported to the LTC inspector that PSW #100's voice was loud, could be interpreted as rude, but that was the way the staff talked. They stated that resident #041 frequently asked for assistance and that PSW's caring for resident #041 and other residents living in adjacent rooms found it difficult to meet all of the resident's needs and was often asked to wait.

During interview, PSW #100 stated that resident #041 did not like the way they spoke to them and that the resident thought that they were their "private nurse".

During interview, the DRC, ADRC, and CEO confirmed that resident #041 and their family member had numerous complaints and sometimes against particular staff persons. The DRC stated that it was difficult to know which complaints were "legitimate". During interview, the DRC, ADRC, and CEO confirmed that the resident's complaints could be interpreted as abuse and neglect, according to legislative requirements. (526)

B) Resident #019's health condition limited their independence and ability to perform hygiene. According to their health records they required extensive assistance from one staff person for hygiene and had been prescribed a treatment for a skin condition.

During this inspection, resident #019 reported to the LTC Inspector that, during evening care they asked PSW #132 to apply additional cream to the affected area. According to the resident, while the PSW had cream on their hand, they then slapped the resident's hand, wiped cream onto it and told the resident to "Do it yourself!". They stated that they had lost their independence and this act and the way the PSW spoke to them was very upsetting. The resident was observed relaying the same story to the DRC.

The resident also told the LTC Inspector that they had told PSW #111 the following day, about this incident. During interview, PSW #111 stated that resident #019 looked upset and distraught as they reported the alleged abuse to them. They confirmed that the PSW #132's actions constituted abuse.

During interview, PSW #132 confirmed that they had told resident #019 to apply the cream themselves. They confirmed that the resident looked upset after they put the cream on their hand and told them to do it themselves, and that they should have sought the assistance of registered staff.

During interview, the DRC confirmed that the home had failed to protect resident #019 from abuse. (526)

C) The licensee failed to ensure that resident #049 was free from neglect by the licensee or staff. According to their health record, resident #049 was a low risk for falls and ambulated independently in the home; they had responsive behaviours and demonstrated restlessness and resistance to care.

i) On a specified day in 2015, resident #049 lost their balance and fell. According

to progress notes it appeared that they had sustained a significant injury to an extremity. The resident's substitute decision maker (SDM) was contacted and asked staff about doing an Xray and managing the resident's pain until the next day. Their pain was not assessed, medication was not administered as prescribed, and a physician or RN in extended class was not informed of the resident's injury. The following morning they were observed to be in pain and their extremity was noticeably injured, at which time they were sent to hospital for treatment. At that time, a family member informed the ADRC that the SDM was not made fully aware of the extent of the resident's injury. According to progress notes, the ADRC indicated that, given their condition, the resident should have been sent to hospital just after they fell.

According to health records and interview with DRC, registered staff attending to resident #049 the specified day in 2015, evening and night shift neglected to i) conduct a post falls assessment; ii) conduct a pain assessment; iii) administer analgesia as prescribed; iv) notify a physician or RN in extended class of the resident's injury; and v) inform the SDM of the full extent of the resident's injury and did not act on the SDM's request that staff inquire about doing Xray. This was confirmed during interview with the DRC.

ii) The resident was returned to the home after receiving treatment for the injury, had a subsequent fall without injury. They began using a wheelchair for locomotion and was removed from hourly monitoring on a specified day. According to progress notes, after dinner the following day, resident #049 fell again. Post fall assessment and pain assessment were not conducted at that time. The resident was noted to have difficulty moving the same extremity that had been previously injured and staff attributed this to their recent treatment. The resident was transferred back to the wheelchair and taken to the activity room. A physician was not notified of the resident's fall. Regularly scheduled medication was administered.

No further notes regarding the status of the resident's extremity were found until four days later, where the condition of the resident's entire extremity had deteriorated and was visibly injured. The physician was notified, the resident was transferred to hospital and treatment was provided.

When the resident returned to the home four days later, they were receiving regularly scheduled medication and were noted to be lying in bed grimacing one day later. No pain assessment was completed from the time of admission until

one week later.

According to health records and interview with DRC, staff attending to resident #049 between the time of their fall and after their return to the home, neglected to i) conduct a post fall assessment; ii) conduct a pain assessment; iii) notify a physician or RN in extended class following the resident's third fall on a specified day in 2015; and iv) assess the resident's extremity when the condition of the extremity had deteriorated.The DRC confirmed that staff neglected to provide resident #049 with treatment, care, services or assistance required for their health and well-being.

D) The licensee has failed to ensure that resident #018 was protected from abuse by staff member #120.

On a specified day in 2016, an incident occurred between the resident and staff member #120 that involved the resident resisting care being provided by the staff member. After the resident resisted receiving care, the staff member grabbed the wrist of the resident to prevent injury to the staff member and in the process, the resident became injured. The morning of the incident, the resident reported to a LTC Inspector that two men had come in and beat them up. The clinical progress notes indicated the incident occurred. The DRC also confirmed the incident occurred. The plan of care directed staff to leave the resident for a few minutes, if they are resistive to care and re-approach with a calm approach. The plan of care was not followed and the resident sustained an injury from the altercation, constituting physical abuse with an injury. (169) [s. 19. (1)] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall do the following:

1. Conduct face to face retraining of all staff regarding the home's policy that staff "Immediately report any witnessed, suspected, or alleged abuse to the charge nurse of Director of Resident Care". Include definitions of abuse, how to identify abuse, and staff's responsibility if they observe or learn of abuse against a resident.

2. Document resident concerns or incidents in residents' health record according to the home's policy.

3. Update the home's "Abuse and Neglect Prevention" policy number NUR-FM-02-01 so that it contains:
i) an explanation of the duty under section 24 to immediately make mandatory reports according to legislative requirements; and
ii) procedures for immediately investigating and responding to alleged, suspected or witnessed abuse and neglect of residents, according to legislative requirements.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual harm/risk
Scope: Isolated
Compliance History: This Non Compliance was issued as a VPC on March 14, 2016, February 5, 2015, January 7, 2015, and September 30, 2013.

2. The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

Review of the home's "Abuse and Neglect Prevention" policy number NUR-FM-02-01 revised March 15, 2016, directed employees to i) "Immediately report any witnessed, suspected, or alleged abuse to the charge nurse of Director of Resident Care"; and ii) "Document or write a brief factual note (e.g. not allegations or opinion) in chart or patient record writing the details of the alleged or witnessed abuse or neglect as soon as possible".

A) Review of resident #045's clinical health record confirmed that on a specified day in 2016, the resident became agitated and hit resident #027, causing injury. The Assistant Director of Care (ADRC) investigated and confirmed that the RPN who witnessed the abuse and documented the occurrence, did not immediately report the incident to the home's management and to the MOHLTC, and confirmed the home's abuse policy was not complied with. (586)

B) Resident #019 reported to the LTC Inspector that during care on a specified day in 2016, PSW #132 slapped cream into their hand and said "Do it yourself!". The resident said that they told PSW #111 the following day. During interview, the DRC confirmed that staff PSW #111 had not mentioned resident #019's allegation of abuse against PSW #132 to them or to registered staff. During interview, PSW #111 confirmed that the resident appeared upset when they told them about the alleged abuse, that the incident was abuse according to the home's policy, and that they had not immediately reported the alleged abuse to the charge nurse or Director of Resident Care according to the home's policy. The DRC confirmed that staff #111 did not comply with the home's "Abuse and Neglect Prevention" policy by not immediately reporting an allegation of abuse.

C) Resident #019 reported to the LTC Inspector that during care on a specified day in 2016, PSW #132 slapped cream into their hand and said "Do it yourself!". The LTC Inspector immediately notified the DRC. The DRC interviewed the resident, confirmed with the LTC Inspector that the resident alleged abuse and described the investigation that was underway. Review of the progress notes revealed that the DRC had not documented the alleged abuse in the resident's health record, according to the home's policy. The DRC confirmed that they should have documented the allegation of abuse in the progress notes according to the home's policy. [s. 20. (1)]

3. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents d) contained an explanation of the duty under section 24 of the Act to make mandatory reports; and e) contained procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

A) Review of the home's "Abuse and Neglect Prevention" policy number NUR-FM-02-01 revised March 15, 2016, indicated the following regarding s. 24 of the Act:

i) that a report was to be "submitted to the MOHLTC within 24 hours by CIS or by telephone on the week-end or holiday; and that a report must be submitted to the MOHLTC within 10 business days" rather than to report immediately according to s. 24(1);
ii)) that the s. 24(1) "requires the facility and certain staff members, to make immediate reports to the MOHLTC where there is a reasonable suspicion that abuse or neglect occurred or may occur" rather than "a person" as stated in s. 24(1); and
iii) that "a report must be submitted to the MOHLTC within 10 days" rather than to immediately report the suspicion and the information upon which it is based to the Director.

B) Review of the home's "Abuse and Neglect Prevention" policy number NUR-FM-02-01 revised March 15, 2016, indicated the following regarding certain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents:

i) that investigation of allegations of abuse should begin "within one business day", rather than immediately according to s.23(1).

During interview, the DRC confirmed that the home's "Abuse and Neglect Prevention" policy did not comply with legislative requirements in terms of investigating and reporting alleged, suspected or witnessed abuse and neglect of residents. [s. 20. (2)]

(526)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall do the following:

1. Immediately investigate every alleged, suspected or witnessed incident of abuse, neglect that the licensee knows of, or that is reported to the licensee.

2. Take appropriate action in response to every such incident;

3. Immediately report to the Director, every alleged, suspected or witnessed incident of abuse, neglect that the licensee knows of, or that is reported to the licensee;

4. Document the home's investigation; according to legislative requirements; and

5. Report back to residents or their substitute decision makers, as appropriate, regarding the outcome of the home's investigation.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual harm/risk
Scope: Isolated
Compliance History: This Non Compliance has not been issued in the past 36 months.

2. The licensee failed to ensure that an incident of abuse was immediately investigated and reported to the Director.

A) On a specified day in 2016, resident #018 sustained two injuries as a result of being physically held by staff member #120. The resident's plan of care directed staff to allow flexibility in ADL routine and to leave and return later to gently try again if resident became resistant. The PSW did not follow the plan of care and this resulted in harm to the resident.

The PSW reported the incident to RN #106, who directed the PSW to report it to the DRC. When the DRC became aware of the incident, an investigation was not initiated immediately. Instead, the PSW was directed by the DRC to not do this again and re-approach the resident next time. The incident was confirmed by the PSW and DRC. The DRC confirmed they did not initiate an immediate investigation or submit a critical incident to the Director. (169)

B) On a specified day in 2016, resident #013 and #014 reported to LTC Inspector that they had been told by nursing staff on night shift to “behave" and not to ring the call bell”. Although they could not remember details about these incidents, resident #013 reported that this made them feel “upset”. Upon learning this, the LTC Inspector reported to DRC that the resident had complained that night staff had told them not to ring the call bell and that this made them feel upset.

During interview several days after initially bringing these concerns to the DRC, the DRC stated that they spoke with resident #013 about continence care, however resident #013 and #014 stated that the DRC had not addressed this issue with them. Review of progress notes revealed that the ADRC followed up with resident #013 as directed by the DRC several days later, pertaining to care concerns during the night (and not about staff being rude and telling the resident not to use the call bell). The ADRC confirmed this. During interview resident #013 and their roommate #014 stated that they did not feel that this issue had been resolved.

(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Order / Ordre :

The licensee shall do the following:

1. Seek advice of the Residents' Council in developing and carrying out the annual satisfaction survey, and in acting on its results.

2. Make the results of the satisfaction survey available to the Residents' Council in order to seek the advice of the Council about the survey under section 85(3) of the Act.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Minimum risk
Scope: Widespread
Compliance History: This Non Compliance was issued as a VPC on February 5, 2015 and as a WN on March 5, 2014

2. The licensee failed to ensure advice of the Residents' Council was sought out in developing and carrying out the satisfaction survey, and in acting on its results.

Review of the home's Residents' Council meeting minutes, interview with the President of the Residents' Council, and interview with the Assistant to the Council confirmed that the home did not seek the advice of the Council in developing and carrying out the home's annual satisfaction survey or in acting on its results. [s. 85. (3)]

3. The licensee failed to ensure the results of the satisfaction survey were made available to the Residents' Council in order to seek the advice of the Council about the survey.

Review of the home's Residents' Council meeting minutes, interview with the President of the Council, and interview with the Assistant to the Council confirmed that the home did not ensure the results of the home's annual satisfaction survey was shared with the Council in order to seek advice of the Council about the survey. [s. 85. (4) (a)]
(586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2016

Order # / Ordre no : 006

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 :

The licensee shall do the following:

1. According to legislative requirements, comply with the following home's policies:

a) "Medication Administration" policy number CNS-00-06-04, where it states "observe the resident taking all of the medications with water provided and never leave medication at side of bed, on table in dining room, at resident's side and always ensure they take the medication";

b) "Medication Disposal" policy number 5.8, where it states "The sealed designated drug destruction container is stored safely and securely in the Home, accessible only to registered personnel, until a medical waste company picks up the destroyed medication";

c) "Administering Routine Medications" policy number 4.2, where it states "Each individual medication is initialed as administered, on the MAR/TAR sheet in the correct boxes (date/time), upon administration and before administering the next resident's medication(s)";

d) "Resident's Individual Narcotic and Controlled Drug Count Sheet" policy which staff are expected to sign when a controlled substance is administered; and the home's "Narcotic Ward Count" sheet policy which oncoming and outgoing staff

are expected to sign after confirming controlled substance counts.

e) "Pain Assessment & Treatment" policy number CNS-00-15-01, where it directed staff to complete pain assessments every week on Saturday for all residents who were on narcotics;

f) "Clinical Assessments" policy number 60.16.10S where it stated that a resident should receive a pain assessment upon return from hospital;

g) "Temperatures of Hot Food-Dietary" policy number GM-01-06, where it directed staff to ensure that hot foods were not held for any length of time at temperatures less than 60 degrees Celsius or 140 degrees Fahrenheit;

h) "Resident Call Bell System" policy number CNS-0007-01, where it indicated that staff used paging devices to alert them to triggered call bells;

i) Update "Resident Call Bell System" policy number CNS-0007-01 to indicate that paging devices are not in use; and

i) "Minimal Lifts" policy number CNS-FM-07-01B, last reviewed on November 6, 2015, stated that "Staff are provided at minimum annual education about the safe use of, inspection of mechanical lifts" as established by the organization.

2. Provide training to all direct care staff on the implementation of the policies itemized above.

3. Conduct audits to ensure that the policies are being complied with.

4. Incorporate the auditing of policy compliance into the home's Continuous Quality Improvement Programme.

Grounds / Motifs :

1. Judgement Matrix:

Severity: Minimal harm or potential for actual harm
Scope: Pattern
Compliance History: This Non Compliance was previously issued as a VPC on February 5, 2015, and March 5, 2014.

2. The licensee failed to ensure that, where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

A) The home's "Medication Administration" policy number CNS-00-06-04, last revised February 22, 2016, directed staff to "observe the resident taking all of the medications with water provided and never leave medication at side of bed, on table in dining room, at resident's side and always ensure they take the medication".

On a specified day in 2016, at approximately 0830 hours, LTC Inspectors observed resident #051 with medications located in a medication cup on the breakfast table beside their plate; registered staff were not in view of the resident. When interviewed, RN #106 stated that the resident must have brought the medications to the dining room from their room. The RN confirmed that they would frequently leave the medications with the resident to self-administer and that the resident did not have a physician's order to self-administer medications.

At approximately 0840, the resident was observed putting the medications in their mouth, at which time a white pill dropped down into their clothing and onto the floor. A dietary aid was assisting the resident and stepped on the pill causing it to be carried about two metres away from the resident. About five staff including two registered staff walked by the medication on the floor and RN #106 did not check to see if the resident had taken their medications. At about 0850, the LTC inspector informed RN #106 that the resident had dropped the medication. The RN picked it up, confirmed that they hadn't noticed that the resident had dropped the medication and had not observed the resident taking the medication. They also confirmed that this was a medication error since they had not observed the resident taking their medication causing the medication to drop and that it had to be replaced with the same medication from another day.

During interview, the ADRC confirmed that staff RN #106 had not followed the home's policy or the home's expectations that the resident be observed while taking their medications, and that the staff RN had not completed an incident report when the medication was spoiled. (526)

B) The home's "Medication Disposal" policy number 5.8 revised July, 2014 directed staff in the destruction and disposal of medications. The policy directed

staff as follows: "Drugs designated for disposal are placed in a designated one-way Medismart drug destruction container provided", and "The sealed designated drug destruction container is stored safely and securely in the Home, accessible only to registered personnel, until a medical waste company picks up the destroyed medication".

On May 24, 2016, the ADRC reported to the LTC Inspector that once regular and controlled medications were destroyed, they would place the one way drug destruction container in the basement in a "Sump Room" and it would stay there until the waste management company came to pick it up approximately every two months. The ADRC confirmed that the storage area was accessible to staff other than registered personnel since maintenance staff had access to the storage area as well. The ADRC confirmed that this storage practice did not comply with the home's "Medication Disposal" policy. (526)

C) The home's "Administering Routine Medications" policy number 4.2, last revised November, 2015, directed staff as follows: "Each individual medication is initialed as administered, on the MAR/TAR sheet in the correct boxes (date/time), upon administration and before administering the next resident's medication(s)".

According to health records, resident #049 fell in 2015, and was noted to have an injury. They were administered a medication twice and were transferred to hospital the following day. Review of their electronic medical administration record (eMAR), indicated that these medications had not been signed as having been administered according to the home's policy. During interview, the DRC stated that it was an expectation that all medications were to be signed by the nurse after they were administered to the resident. During interview, the DRC confirmed that the home's policy had not been complied with when staff failed to indicate in the eMAR that resident #049 received a medication. (649)

D) According to interview with the home's ADRC and DRC, and review of the home's Medication Management System registered staff were required to complete a "Resident's Individual Narcotic and Controlled Drug Count Sheet" at the time of administration for each controlled substance administered to each resident. The home's expectations also required oncoming and outgoing registered staff to count controlled substances located in the controlled substance storage area during shift change and to indicate the count of each resident's controlled substance medication on the home's "Narcotic Ward Count"

sheet.

During inspection of the home's medication management system conducted at approximately 1030 hours on May 24, 2016, LTC Inspector observed that registered staff #115, #106 had failed to sign the home's "Resident's Individual Narcotic and Controlled Drug Count Sheet" and "Narcotic Ward Count" for controlled substances administered to residents in the home. The registered staff confirmed this. In addition, three count sheets on the first floor had outgoing signatures for counts that had not yet occurred for the 1450 hours shift change count; this was confirmed by RPN #114.

During interview, the ADRC and DRC confirmed that staff had not followed the home's policy on documentation of controlled substance administration on the "Resident's Individual Narcotic and Controlled Drug Count Sheet" on May 24, 2016, and shift change counts on the "Narcotic Ward Count" sheets on May 23 and 24, 2016. (526)

E) The home's "Pain Assessment & Treatment" policy number CNS-00-15-01, last revised May 19, 2016, directed staff to complete pain assessments every week on Saturday for identified residents. Resident #015 fit the criteria for pain assessment. During a three month time period, review of the resident's health record identified that the resident only received seven out of twelve weekly pain assessments. The DRC confirmed the home's pain policy was not complied with since the resident had not received weekly pain assessments. (586)

F) According to the home's policy titled "Pain Assessment and Treatment" (policy # CNS-00-15-01, last revised May 19, 2016) stated, pain assessment was to be completed on specified residents. Resident #049's health record indicated that resident met these criteria during a two week time period in 2016, after returning from hospital, during which time, their pain was not assessed according to the home's policy. During interview, the DRC confirmed that the home's policy was not followed as a weekly pain assessment should have been initiated immediately upon return from hospital.

G) The home's "Clinical Assessments" (policy number 60.16.10S, last revised 16/08/2013) stated, that a resident should receive a pain assessment upon return from hospital. A review of resident #049's health record indicated that upon return from the hospital on a specified day in 2015 no pain assessment was completed until three days later. During interview, the DRC confirmed that

the home's policy had not been complied with. (649)

H) The policy named "Temperatures of Hot Food-Dietary" GM-01-06, revised February 2, 2016 directed staff to ensure that hot foods were not held for any length of time at temperatures less than 60 degrees Celsius or 140 degrees Fahrenheit. On June 1, 2016 during observation of the dinner meal on first floor, the temperature of the pureed entree of meat was probed by the dietary aide at 1745 hours at 50 degrees Celsius. The food in the servery was being held at temperatures less than 60 degrees Celsius, according to the policy. This was confirmed by the Food Service Supervisor. (169)

I) The licensee failed to ensure that the home's "Resident Call Bell System" policy number CNS-0007-01 was complied with. The policy was last revised on May 6, 2016 and directed staff to use their pagers to manage the resident call bell system. Observation throughout the entire home confirmed there were no pagers used in the home. The PSW's on first and second floor home areas and DRC confirmed there were no pagers available with the call bell system. (169)

J) The home's "Minimal Lifts" policy number CNS-FM-07-01B, last reviewed on November 6, 2015, stated that "Staff are provided at minimum annual education about the safe use of, inspection of mechanical lifts" as established by the organization. Interview with the DOC confirmed that all staff were to receive safe lifts and transfers training on an annual basis. In an interview with the Education Coordinator, they confirmed to LTC Inspectors #526 and #169 that the Faith Manor staff were not receiving safe lifts and transfers training annually. (586)
(169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:

1. Enhance the home's existing "Bed System Assessment" to include additional questions and guidance related to bed safety hazards found in the prevailing practices identified by Health Canada in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".

2. An interdisciplinary team shall assess all residents using the comprehensive and amended bed safety assessment tool and document the results and recommendations for each resident who uses bed rails for any reason and update the resident's written plan of care if necessary.

3. Ensure that where residents who have been provided with a therapeutic air mattress and who require the use one or more bed rails be provided with appropriate accessories to mitigate any identified safety hazards including entrapment risks and institute a monitoring program that will ensure that residents who require accessories to reduce any identified entrapment zones will continue to be provided with those accessories.

Grounds / Motifs :

1. The licensee failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Review of the home's bed entrapment audit conducted during June and July, 2015, included the completion of the "Bed System Inspection Form" for each bed system. The audit revealed that seven beds failed zones of entrapment. The residents who resided in these beds were observed on June 1, 2016, laying in the beds with the bed rails causing failed zones of entrapment in the raised position. During this observation, no bed accessories were observed on or around the elevated bed rails and confirmation was made by the bed safety lead involved in assessing the residents that no accessories had been implemented.

According to the "Bed Safety Assessment", section #3, beds with therapeutic air mattresses were not tested for zones of entrapment and therefore section 3B was not completed to determine what actions or steps were necessary to reduce or mitigate the zones of entrapment. Discussion was held with the bed safety lead that the questionnaire needed revisions and that all residents using a therapeutic air mattress would require safety interventions as the beds typically fail one or more entrapment zones due to their soft design. Preventative steps were therefore not taken to mitigate the zones of entrapment for residents #003, #165, #011, #166, #013, #014, and #167 who were residing in beds with and without air mattresses that failed zones of entrapment. [s. 15. (1) (b)] (526)

2. Judgement Matrix:

Severity: Minimal harm or potential for actual harm
Scope: Pattern
Compliance History: This Non Compliance was previously issued as follows:
i) An immediate Compliance Order was issued and complied with on March 14, 2014, for not ensuring that steps were taken to minimize the risk for all entrapment zones of three specified bed systems;
ii) A Compliance Order was issued on April 7, 2014, reissued on June 5, 2015 and complied with on March 30, 2016.
(526)

3. The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

According to prevailing practices tilted "Clinical Guidance 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 adopted by Health Canada), all residents who use one or more bed rails were to be evaluated by an interdisciplinary team, over a period of time while in bed to determine safety risks associated with bed rail use. To guide the assessor, a series of questions would be completed to determine whether the bed rail(s) were a safe device for residents while fully awake or while they were asleep. The guideline also emphasized the need to document clearly whether alternative interventions were trialled before bed rails were implemented and if the interventions were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the resident's medical status, cognition, behaviours, medication use, mobility and any involuntary movements, falls risks, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed), environmental factors and the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or their Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device).

The final conclusion would be documented as to why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not developed fully in accordance with prevailing practices as identified in the above guideline. According to the licensee's policy titled "Bed Rails" date February 5, 2016, a questionnaire was to be completed by the Registered Nurse (RN) titled "Bed System Assessment" on their computer system for each resident. Verification was made that the "Bed System Assessment" was completed for all residents, however the questions and processes identified in the prevailing practices identified above were not fully included. The licensee's policy identified that at the conclusion of the assessment, the nurse would "determine, based on the assessment, whether the bed rail was a restraint or a PASD (Personal Assistance Services Device). No reference was made in the policy regarding a conclusion of potential risk and how to ensure that the bed rail was safe for the resident in their assessed

condition. The only reference made to bed safety hazards in the policy fell under section (c) directing the RN to discuss with the resident or their SDM the risks associated with the bed rails.

Review of the home's bed entrapment audit conducted during June and July, 2015, included the completion of the "Bed System Inspection Form" for each bed system. The audit revealed that seven beds failed zones of entrapment for residents #003, #165, #011, #013, #014, #166, and #167; some of these bed systems involved the use of air mattresses.

Review of the health records for the residents residing in these beds revealed that they had not been assessed in these bed systems to minimize their risk of entrapment according to best practice as discussed above. The DRC confirmed that the PASD assessment instrument did not address best practices as mentioned above, and these residents had not been assessed to minimize their risk for entrapment. [s. 15. (1) (a)]
(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall do the following:

1. Staff will use transferring and positioning devices and techniques according to the residents' assessed needs and their plan of care when assisting all residents.

2. Transfer resident #015 using a full mechanical lift according to their plan of care.

3. Ensure there are sufficient lift devices and equipment available in the home at all times based on resident need.

4. Train all staff on the safe lifts and transfers policy, including an annual re-training and staff shall receive training as needed based on resident change in condition.

5. Develop a process that ensures communication to all front line staff of each resident's transfer status, and ensure all residents are being transferred according to their assessed need.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual Harm/Risk
Scope: Isolated
Compliance History: This non compliance was issued as a VPC on November 13, 2014.

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

Review of resident #015's health record and interviews with PSWs #119, #111 and #121 confirmed that staff would either use the full mechanical lift or the sit-to-stand lift to transfer the resident, depending on what was available at the time. This was confirmed during interview with the resident.

Review of the resident's most recent Transfer Ability Assessment indicated that the resident required the use of a specified transfer device and was unable to use another device available to staff to transfer residents. This was confirmed in their most recent Significant Change in Status Assessment and in their plan of care.

Interview with the Occupational Therapist (OT) confirmed that they witnessed PSWs transferring the resident to bed using the lift that the resident was identified as unable to use. Interview with the Physiotherapy Assistant (PTA) confirmed that the staff should not use the lifting device with resident #015 and said it was "not safe". The staff did not use safe transferring devices when assisting resident #015. [s. 36.] (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee shall do the following:

1. Assess a resident after they have fallen using a clinically appropriate instrument that is specifically designed for this purpose according to the home's policy.

2. Notify the Physician or Registered Nurse in extended class immediately according to the home's policy so that the resident's condition can be assessed and treatment provided according to their needs.

3. Update the plan of care for residents who have fallen to include falls prevention interventions.

4. Retrain all direct care staff on the home's policies for post fall assessment, lifts and transfers post fall, referral to physician/RN in extended class, pain management post fall, and documentation of assessments, interventions and evaluation of care.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual harm/risk
Scope: Isoalted
Compliance History: This non compliance has not been issued within the past 36 months.

2. The licensee failed to ensure that when a resident had fallen, the resident was assessed, and that where the condition or circumstances of the resident required, a post fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

A) Review of resident #049's health records indicated that on a specified day in 2016, they lost their balance and fell, causing injury. They required staff assistance to ambulate and a post-fall assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for falls at that time. They were admitted to hospital the following day and required treatment. According to their health record no post-fall assessment was conducted using a clinically appropriate assessment instrument immediately after the fall or at any time thereafter before they were sent to the hospital.

During interview, the DRC stated that it was the homes' expectation that the staff conduct a post-fall assessment prior to moving the resident after a fall, and confirmed that resident #049 was not assessed using a clinically appropriate assessment instrument that was specifically designed for falls, between the time of their fall and their hospitalization.

B) After returning from hospital, resident #049 had another fall with no injury. Review of their health record revealed that no post fall assessment was conducted at that time.

C) According to health records, resident #049 had a fall on a specified day in 2015 and were noted to have difficulty moving an extremity. A review of their health records revealed that no post fall assessment was completed after the fall. Several days later the condition of the extremity had deteriorated and was noticeably injured. The resident was hospitalized at which time they received treatment. A review of the health record indicated that a post-fall assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for falls between the time of the fall and their admission to hospital.

During interview, the DRC confirmed that staff failed to conduct a post-fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls after resident #049 fell on three separate occasions in 2015, and that this may have contributed to a delay in the resident receiving the necessary treatment and pain management. [s. 49. (2)]

(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 010

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(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).

Order / Ordre :

The licensee shall do the following:

1. Conduct a skin assessment by a member of the registered nursing staff, on all residents including resident #013, who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

2. As per the home's expectation, non-registered staff shall follow the home's policy "Skin Inspection - Bathing" number 30-08-16 (last reviewed April 11, 2015) by completing the "Bathing Skin Inspection" form on each resident with impaired skin condition at each bath or shower.

3. All residents, including resident #013, who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, will receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

4. All residents, including resident #018, exhibiting altered skin integrity, including skin tears, will be reassessed at least weekly by a member of the registered nursing staff, and the plan of care will be reviewed and revised according to that reassessment.

5. Re-train:
i) all registered staff on the use of the home's clinically appropriate assessment tool skin assessment;
ii) all non-registered staff on the process for weekly skin assessments, including documentation;
iii) all direct care staff on providing immediate treatment and interventions to reduce pain, promote healing and prevent infection for residents who have alteration in skin integrity

6. Develop a process to ensure that all staff are following the skin and wound policy, including the above stated re-training.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual harm/risk
Scope: Pattern

Compliance History: This Non Compliance was issued as a VPC on March 5, 2014.

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

According to their health record, on a specified day in 2016, resident #013 had developed an area of altered skin integrity and was prescribed a daily treatment. During interview, resident #013 complained to LTC Inspector that they had pain related to skin and wound, and transferring and positioning issues. Progress notes and interview with the ADRC indicated that the resident's altered skin integrity had worsened since initially identified.

Review of their health record and interview with ADRC revealed that staff had not conducted a pain assessment using a clinically appropriate assessment instrument over a 25 day period in 2016, according to the home's expectations when a resident had an area of altered skin integrity. Interventions to manage the resident's pain had not been initiated. In addition, their plan of care had not been updated when the resident developed the alteration of skin integrity. The ADRC confirmed that the plan of care should have been updated. The ADRC confirmed that resident #013 had not received interventions to reduce or relieve pain, promote healing, and prevent infection, as required. [s. 50. (2) (b) (ii)]

3. The licensee failed to ensure that, when a resident exhibited altered skin integrity, including skin tears, they were reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

A) Resident #003 had a chronic area of altered skin integrity. A review of the past three months clinical notes revealed that as the condition of the area worsened, 7 out of 12 reassessments were not completed. The Registered Nurse (RN) #106 confirmed the weekly wound reassessments, which were to be completed on Saturdays, were not consistently completed and that the area of altered skin integrity worsened.

B) The licensee failed to ensure that when resident #018 exhibited an area of altered skin integrity, that it was reassessed at least weekly by a member of the registered nursing staff. According to health records, resident #018 sustained an

area of altered skin integrity on a specified day in 2016 that worsened and required treatment. The area was not reassessed until 12 days after the assessment that identified the skin condition had worsened. This was confirmed by the RN #106 and clinical documentation.

C) According to their health record, on a specified day in 2016, resident #013 was noted to have developed an area of altered skin integrity and was prescribed a daily treatment. During interview, resident #013 complained to LTC Inspector that they had pain related to skin and wound, and transferring and positioning issues. Progress notes and interview with the ADRC indicated that the resident's altered skin integrity had worsened over the next 25 day time period.

Review of health records indicated that an intial skin and wound assessment was not completed when the area of altered skin integrity was observed, and a reassessment was completed by a registered staff one time during the next 25 day period. In addition, no head to toe skin assessments had been completed by non registered staff on the resident's bath day according to the home's expectations during that time.

Progress notes and interview with the ADRC indicated that the resident's area of altered skin integrity had worsened after 25 days. During interview, the ADRC confirmed that resident #013's altered skin integrity had not been assessed initially or weekly by a member of the registered nursing staff when clinically indicated, that PSW staff had not documented the status of the resident's skin during that time, and that the resident's skin integrity had deteriorated over a 25 day period in 2016. [s. 50. (2) (b) (iv)] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 011

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall do the following:

1. Among residents were are incontinent, where conditions or circumstances of the resident applies, and according to the home's policy, assess residents' (including residents #041 and #014) bowel and bladder continence using a clinically appropriate assessment instrument to identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

2. Develop and implement individualized plans of care based on the assessment, to promote and manage bowel and bladder continence for each resident that includes level of assistance required, frequency and timing of toileting, the type of transfer to be used and whether supervision is required during toileting.

3. Monitor residents for signs and symptoms of urinary tract infection (UTI) and initiate referral to physician or RN in extended class as needed.

4. Re train all direct care staff on the home's bowel and bladder continence programme, including continence assessments, the development and implementation of their individualized plan of care to promote continence and safety of the residents.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual harm/risk
Scope: Widespread
Compliance History: This Non Compliance was previously issued as a VPC on February 5, 2015,

2. The licensee failed to ensure the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment.

A) Resident #041's most recent RAI MDS assessment completed in 2016, indicated that they were incontinent and required total assistance from two staff for transferring; this was confirmed by PSWs #102, #103 and RN #101. The resident's most recent continence assessment outlined the care provided to the resident. Resident #041 complained to the LTC Inspector that, on a specified day in 2016, PSW #100 did not toilet them, causing them to become incontinent,

or provide hygiene care as usual, and stated feeling upset about this since they might develop complications as the result of care not being provided. The resident also stated that there had been times when staff would not attend to or delayed attending to them for over 20 to 30 minutes if they needed to use the toilet. They confirmed that their family member would transfer them to the toilet because the staff were not always available. During the course of this inspection, LTC inspector observed resident #041's family requesting assistance with toileting and PSW staff responded that the resident was not “their resident” and did not assist.

PSWs #100 and #111 who were caring for resident #041 on the specified day in 2016, confirmed the resident's accounts as noted above. PSW’s #102, #103, and #104 described different information about the resident's toileting preferences which was also different from the description provided by RN #106 and the DRC.

During interview, ADRC and DRC confirmed that resident #041’s continence plan of care was not individualized based on an assessment, or implemented to promote and manage bladder continence.

B) Review of resident #041’s health record and resident interviews indicated that they were at risk for developing a health condition that required treatment. During interview, the resident stated that they were exhibiting symptoms of the health condition and expressed concerns when they had not received care to prevent the health condition.

During interview, RN #106 confirmed that the resident was at risk for the specified health condition. They stated not knowing that the resident had symptoms and thought that these symptoms were a regular behaviour for them, but could also indicate the presence of the health condition that they were at risk for developing. The RN and the DRC confirmed that an individualized plan of care had not been developed to monitor the resident’s risk for the health condition as a way to promote and manage bladder continence for resident #041.

C) According to their health record, resident #014 was at high risk for falls and had mobility limitations so that they required the use of a wheelchair. Health records indicated that they were frequently incontinent and specified that two staff were needed for toileting, supervision and safety. This was confirmed by

the physiotherapy assistant (PTA) staff #110, and PSWs #103 and #124. The PTA and PSWs confirmed that the resident became impatient waiting for assistance with toileting and would risk their safety by self-transferring. The PSWs also stated that almost always, the resident would transfer themselves to the toilet and ring the call bell for help to transfer from toilet to their wheelchair.

During interview, PSWs #110 and #124, the DRC, and ADRC confirmed that resident #014's plan of care was not implemented when the resident would wait for assistance and then toilet themselves, instead of two staff persons assisting them. They confirmed that the resident's risk for falls was increased when the plan of care to promote and manage bladder continence was not implemented. [s. 51. (2) (b)] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 012

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee shall do the following:

1. Assess all residents' pain, including residents #041, and #019, using a clinically appropriate assessment instrument specifically designed for this purpose when their pain is not relieved by initial interventions.

2. Provide analgesia as prescribed, reassess its effectiveness and document accordingly.

3. Contact the physician/RN in extended class if pain management strategies are not effective.

4. Retrain all direct care staff in the home's pain management policy to include recognition of pain and pain assessment when initial interventions have not been effective.

5. Evaluate the home's pain management programme according to legislative requirements.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Harm/actual harm
Scope: Isolated
Compliance History: No non compliance has been issued within the past 36 months.

2. The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) According to health records and interviews with resident #041, they had experienced pain during the previous six months. Review of their eMAR indicated that they received pain medication as needed almost daily over the past six months in addition to regularly scheduled pain medication.

Review of their health record indicated that their pain had not been assessed using a clinically appropriate assessment instrument specifically designed for this purpose for at least one year from the time of this inspection. During interview, the DRC confirmed that resident #041's pain should have been assessed using clinically appropriate assessment instrument specifically designed for this purpose since their pain had not been relieved by initial interventions. (649)

B) Pain assessments had not been completed for resident #049 as follows, when initial interventions had not been effective:

i) Resident #049 fell on a specified day in 2015. According to progress notes, the resident showed signs of injury and pain. During interview, the DRC confirmed that no pain assessment was completed at this time.

ii) According to progress notes, hours after resident #049 had fallen, they showed signs of severe pain, were administered medication that was not effective in alleviating the pain. They were transferred to the hospital where they received treatment for the injury. A review of the health records indicated that their pain had not been assessed using a clinically appropriate assessment instrument specifically designed for this purpose when initial pain management interventions were not effective before they were transferred to hospital.

iii) Resident #049 fell on a different day in 2015 and several days later, an extremity was noted to be injured. They were transferred to hospital where they received treatment for the injury sustained and returned to the home several days later. Review of health records indicated that a pain assessment was not completed upon return from hospital after surgery until several days later. The resident was not administered pain medication as ordered and progress notes indicated that they were experiencing pain. Staff failed to document the

administration of the medication according to the home's policy and no pain assessments were found when initial interventions were not effective in alleviating the resident's pain.

The DRC confirmed that resident #049's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose after their fall and then not again after return from hospital for several days when their pain was not relieved by initial interventions. The DRC further stated that the home's policy for pain assessment was not followed during this time. (649)

C) During interview, resident #019 complained to LTC Inspector that they were having pain. Review of their health records indicated that they had complained of pain six times during a three day period and could not sleep due to pain during a 10 day period in 2016. Medication administered during these time periods was noted as being ineffective.

Review of their health record indicated that they had not had a pain assessment using a clinically appropriate instrument specifically designed to assess pain over a four month time period that covered the incidents noted above.

During interview, the RAI Coordinator was asked about notifications to staff that informed them when a pain assessment was overdue for resident #019. They stated that this flag was usually ignored and cleared. The DRC confirmed that resident #019's pain over a two month time period in 2016 should have been assessed using a clinically appropriate assessment instrument specifically designed for this purpose when their pain had not been relieved by initial interventions. (526) [s. 52. (2)]
(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 013

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

Pursuant to / Aux termes de :

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

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall train all direct care staff including non registered staff in the home's pain management programme by the compliance date and annually.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Minimal harm/potential for actual harm
Scope: Pattern
Compliance History: Previous Non Compliance in a similar area (staff training)

2. The licensee failed to ensure that direct care staff were provided training in pain management, including recognition of specific and non-specific signs of pain.

In accordance with paragraph 6 of subsection 76(7) of the Act, review of the home's mandatory training records for all direct care staff revealed that only registered staff had received training for the home's pain management programme during 2015. During interview the home's staff educator confirmed that non registered staff who also provided direct care to residents had not received mandatory training for pain management in 2015 and had not been offered training in 2016 as of the time of this inspection. During interview the DRC confirmed that not all direct care staff had received training for the home's pain management programme in 2015. (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 014

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable

assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall do the following:

1. Retrain all staff in the home regarding promoting and protecting residents' right to be afforded privacy in treatment and in caring for his or her personal needs.

2. Take steps to ensure that residents' right to be afforded privacy in treatment and in caring for his or her personal needs is fully respected, including when staff enter their rooms, while receiving care in their rooms and when in the hallway while waiting for their showers.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Minimal harm or potential for actual harm
Scope: Pattern
Compliance history: Previous unrelated non compliance

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

A) Residents #013 and #014 lived in the same room. During interview with the LTC Inspector, the following incidents occurred on specified days during 2016:

i) PSW #121 entered the closed door without knocking to turn off the call bell; provided care to resident #013 and left the room;

ii) PSW #121 entered the closed door to their room without knocking, interrupted the interview and stayed while LTC inspector tried to complete the interview;
iii) PSW #122 entered the closed door to their room without knocking, interrupted the interview and said "I'm just checking the room", entered the residents' washroom, stayed for approximately two minutes, left the room with the door ajar saying that they weren't finished, entered the room again, and then left closing the door.

When resident #014 was asked if staff entered the room without knocking, they stated that their room was their home and reported that staff frequently did not knock prior to entering their room. During interview, PSW #103 stated that usually the residents' door was opened and they didn't have to knock; they confirmed that they should have knocked before entering to respect the resident's privacy and their personal needs.

B) On a specified day in 2016, resident #011 was observed from the hallway, through the doorway to their room receiving care from two PSWs as two registered staff entered their room with the treatment cart. The resident was observed in their bed, being turned away from the door; the privacy curtain had not been pulled around them. Approximately five minutes later, LTC Inspector returned to the door that was approximately six inches ajar and observed four staff in the room and could view the resident receiving care.

During interview, PSW #123 who was caring for the resident stated that they thought that the privacy curtain had been closed, was not aware that it was open, and confirmed that it should always be closed.

During interview, the DRC and ADRC confirmed that staff should knock prior to entering rooms and also ensured that they had privacy during care. They confirmed that the home had not protected and promoted resident's #013, #014, and #011 right to be afforded privacy in treatment and in caring for his or her personal needs.

C) The licensee failed to ensure that resident #160 was provided privacy while going to the washroom. On a specified day in 2016, the resident was observed sitting on the toilet, with their pants down and the door open approximately 12 inches. The resident's naked bottom and legs were fully visible to any one walking by in the shared room. The resident confirmed the staff do this practice all the time and leave the door open. (169)

D) The licensee failed to ensure that resident #054 was afforded privacy in caring for their personal needs. On a specified day in 2016, resident #054 was observed sitting in their wheelchair in the hallway, outside the shower room. The resident was crying and was distressed. Staff member #120 was observed walking by and telling the resident they would get into the shower in a few more minutes. The resident responded by stating they had been waiting a long time already. Ten minutes went by and the same staff member was observed walking by and telling the resident they would again, get into the shower in a few more minutes.

After their shower, the resident was interviewed and identified they were very upset about sitting in the hallway without proper covering on. The resident identified they were awoken by the staff member #120 very early and then were made to wait for a long time before going to the shower. Staff member #120 confirmed the resident was waiting for about ten minutes for their shower and was only wearing a housecoat, with their blue brief sitting on their lap. The resident was not treated with respect and provided privacy while waiting for their shower. (169) [s. 3. (1) 8.]
(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 19th day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa McMillan

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