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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 19, 2017	2017_597655_0016	014829-17	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

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

MICHELLE EDWARDS (655), MELANIE SARRAZIN (592), RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, and 23, 2017.

The following Critical Incident was inspected concurrently: Log #011821-17, related to an allegation of resident-resident physical abuse.

During the course of the inspection, the inspector(s) spoke with residents and family members, Personal Support Workers (PSWs), Registered Nursing staff (RNs and RPNs), a Laundry Aide, Dietary Aide, Environmental Services Aide, the Life Enrichment Coordinator, the Resident Assessment Instrument (RAI) Coordinator, the Environmental Services Manager, the Resident Services Coordinator, the Assistant Director of Care (ADOC), the Director of Care (DOC), and the Administrator.

During the inspection, the Inspectors also observed the provision of resident care and services; and, reviewed resident health care records, policies and procedures, night duties schedules, bathing schedules, staff training records, documentation related to bed system evaluations, internal complaints/concern reports, and incident investigation notes.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and that those doors were kept closed and locked when they are not being supervised by staff.

On August 08, 2017, Inspector #592 observed an unlocked and unsupervised room located on the fifth floor in the entrance of the north unit. The room was a non-residential space, and contained two electric panels and one other control panel. The inspector noticed that the room was accessible to the unsupervised residents walking in the area.

On August 8, 2017, Inspector #592 observed an unlocked and unsupervised room located on the fourth floor beside the lounge room on the south wing corridor. The room was a non-residential area, and contained two electrical panels. The Inspector noticed that the room was accessible to the unsupervised residents walking in the area. In addition, an unlocked and unsupervised room located in the entrance of the north unit was also observed. The second room was non-residential, and also contained one electrical panel which was observed to have wires coming out of it. No lights were accessible to the Inspector in this room. The Inspector noticed that the second room was also accessible to the unsupervised residents walking in the area.

On August 8, 2017, Inspector #592 observed an unlocked and unsupervised room (room #346) located on the third floor at the end of the south corridor. It was a non-residential area, and contained gallons of Virex 256, Stride Citrus and Oxi Pur products with a central dispenser. The Inspector noticed that the room was accessible to the unsupervised residents walking in the area.

On August 10, 2017 at 0951 hours, Inspector #655 observed that on the fifth floor, the nurses' station door was open and unlocked. No nursing staff were observed to be in the area at the time of the observation.

On August 11, 2017 at 1110 hours, Inspector #655 observed on the fifth floor, the nurses' station door was open and unlocked. Eight residents were observed to be seated in the lounge area beside the nurses' station; while no nursing staff were observed to be in the area. The nurses' station was accessible to the unsupervised residents.

On August 14, 2017 at approximately 1045 hours, Inspector #655 and #548 both observed that on the fifth floor, the nurses' station door was open and unlocked. Six residents were observed seated in the lounge area next to the open door; and there were no nursing staff observed to be in the area at the time. The nurses' station was

accessible to the unsupervised residents.

On August 15, 2017 at 1005 hours, Inspector #592 observed room #346, the same room identified during the initial tour located on the third floor at the end of the south corridor. At the time of the observation, the door of room #346 was again observed to be unlocked; and the area was again unsupervised with no staff members observed to be in the area at the time. Still, the room contained gallons of Virex 256, Stride Citrus and Oxi Pur products with a central dispenser. The Inspector noticed that the room was accessible to the unsupervised residents walking in the area.

At the time of the observation, PSW #107 was approached by the Inspector. At that time, PSW #107 indicated to the Inspector that the door of room #346 was the housekeeping room, where disinfectant was stored and used; and that it was expected to be kept closed and locked at all times. At the same time, PSW #107 indicated that he/she was unable to lock the door as he/she did not have the key. PSW #107 indicated to the Inspector that he/she would follow-up with the registered nursing staff about this concern.

PSW #107, accompanied by the Inspector, went to report the concern to RN #114, who immediately went with the Inspector and locked the door. RN #114 indicated that the door should be kept closed and locked at all times; and that the housekeeping department would be notified for follow-up.

During an interview on August 16, 2017, ADOC #112 indicated to the Inspector that the above-noted rooms should be kept closed and locked at all times since the rooms contained electrical panels and housekeeping products which may constitute a potential risk for the residents.

The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when the areas were not supervised by staff. [s. 9. (1) 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 all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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.

During the inspection, Inspector #655 observed evidence of altered skin integrity on a specific area of resident #037's body.

During the inspection, Inspector #592 also observed evidence of altered skin integrity in the same area of resident #037's body.

Inspector #592 reviewed resident #037's health care record, including care plan and progress notes.

In the health care record, it is indicated that resident #037 was admitted to the home on a specified date with multiple diagnoses.

In resident #037's current care plan, resident #037 was identified as being at risk for altered skin integrity, related to several conditions. However, there was no indication in the current care plan or in the progress notes that resident #037 had any form of altered skin integrity on the area of the body that was observed by the Inspectors.

During an interview, RN #133 indicated to the Inspector that he/she was not aware of the skin status of resident #037; and was not aware of any specific skin-related treatments. RN #133 further indicated that when an alteration in skin is reported, the registered staff will assess the skin issue and document in the resident's progress notes. The results of the assessment and the appropriate treatments would also be documented in the progress notes. In addition, registered nursing staff would document on the wound tracker tool - the same tool that would be used to conduct weekly skin assessments. RN #133 further indicated that the skin-related treatment (s) would be specified on the Treatment Administration Records (TARS), for the staff to follow. The plan of care would also be updated to reflect the actual care for the issue of altered skin integrity. At the time of the interview, RN #133 was unable to determine the date at which the skin alteration was first identified on the specified area of resident #037's body as there was no wound tracker found, no indication in the progress notes, and no TARS for resident #037.

During an interview, ADOC #112 indicated to the Inspector that when a new skin issue is reported, the nurses are to complete a skin assessment and act accordingly as per their skin program. ADOC #112 further indicated that a progress note will be documented based on the skin assessment and that the staff will then refer to their "healthy living healthy skin" program for specific interventions. According to ADOC #112, a wound tracker will be used for alterations in skin integrity- the same document used for weekly skin assessments, as per their protocol. When the Inspector inquired about the skin issue of resident #037, ADOC #112 was unable to find any information related to the alteration in resident #037's skin integrity within resident #037's electronic health care records. ADOC #112 told the Inspector that he/she would follow-up with the registered nursing

staff on the floor.

Resident #037's skin was later assessed by RN #133. According to a progress note, resident #037's skin alteration on the specified area of resident #037's body was determined, at that time, to be of unknown origin. The note also included additional assessment information related to the identified skin alteration.

During an interview, ADOC #112 indicated that the home's skin process was not followed as he/she was unable to find any documentation of an initial skin assessment for resident #037. ADOC #112 was unable to determine when the skin alteration commenced. [s. 50. (2) (b) (i)]

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 residents exhibiting altered skin integrity, including resident #037, receive 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, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

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

Inspector #592 reviewed resident #031's health record related to the use of specified

medications.

According to the health care record, resident #031 was admitted to the home on a specified date with multiple diagnoses. The resident's health record indicated that resident #031 was identified as having certain responsive behaviours.

It was further indicated in the resident's health care record, that resident #031 was followed by a consulting physician who had recommended specific medication changes.

Inspector #592 reviewed the "Digital Prescriber's Orders" which indicated that on a specified date, the recommendations for the above- noted medication changes from the consulting physician were authorized by the home's physician; and were signed by a member of the registered nursing staff, an RPN.

Inspector #592 reviewed resident #031's Medication Administration Records (MARS) which indicated that resident #031 was being administered specified medications in doses that were not consistent with the specific medications changes ordered on a specified date.

During an interview, RPN #117 indicated to Inspector #592 that any medication changes that are recommended by a consulting physician for resident #031, would then be authorized by the home's physician. RPN #117 further indicated that some medication changes were recommended by the specified consulting physician on a specified date. According to RPN #117, those changes were authorized on a specified date by the home's physician. RPN #117 indicated that he/she was the staff member responsible for processing the order on the specified date, by transcribing the order after receiving authorization from the home's physician. RPN #117 indicated that the order was sent to the pharmacy using the Pharmacy digital pen. However, RPN #117 noted in the presence of the Inspector that the resident had not been receiving the proper medication dosages, as per the new physician orders.

On the same day, RPN #117 indicated to the Inspector - after following up on the medication discrepancies for resident #031- that the order received on a specified date did not go through to the pharmacy. That is, the pharmacy did not receive the new orders for resident #031. As a result, the drugs administered to resident #031 were not administered in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that drugs were administered to resident #031 in

accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs are administered to resident #031 in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #031 as specified in the plan.

During the inspection, Inspector #655 observed that resident #031's mattress was not secured on the mattress deck. The mattress had slid to one side, exposing the bed deck. At the time of the observation, the mattress was hanging over the edge on the right side.

During the inspection, Inspector #548 and Inspector #592 also observed resident #031's mattress to easily slip from side to side, exposing the bed deck. Inspector #548 informed the Administrator.

During an interview with Inspector #548, the Assistant Director of Care (ADOC) and Director of Care (DOC) informed the inspector that resident #031's mattress had been changed; and, mattress keepers were put in each corner of the bed. At the same time, Inspector #548 was informed that hourly checks had been implemented for a specified number of days in order to monitor the mattress placement on resident #031's bed.

The resident's current care plan specifies that staff are to monitor mattress placement hourly for a specified number of days.

Over the course of the inspection, Inspector #548 observed resident #031 sleeping in bed. On a specified date, the right side of the mattress top and foot were out of the mattress keepers. On the same day, a period of time later, the resident was observed to be sleeping in bed and the mattress was out of the top and the bottom mattress keepers on the right side.

During an interview with inspector #548, RPN #105 indicated that the PSWs were to conduct and document their hourly checks of the mattress placement.

On the same day, during an interview with Inspector #548, PSW #115 indicated that he/she had observed the mattress placement at a specified time in the morning that day, and hourly thereafter. PSW #115 explained that hourly checks are done to ensure that the mattress remains in the mattress keepers at each corner. The inspector informed PSW #115 of the observations, as described above. PSW #115 indicated he/she had not checked the mattress placement for all four mattress keepers during the hourly checks.

The licensee failed to ensure that the care set out in the plan of care, related to hourly checks of mattress placement, was provided to resident #031 as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that when resident #031 was reassessed, the plan of care was reviewed and revised.

Resident #031 was identified as being at a risk for falls, and as being able to self-transfer between surfaces with care staff support.

During the inspection, Inspector #548 observed resident #031 to be in bed in the presence of two PSWs, PSW #115 and PSW #166. At that time, the resident mobilized to

a sitting position. Resident #031 indicated to the inspector that he/she uses a specific assistive device to get out of bed and that the staff remind him/her to do so. Both PSWs indicated that resident #031 mobilizes with their assistance, if required, between surfaces using a specificied assistive device. The assistive device was observed to be at the resident's bed side.

On the same day, during an interview, RPN #105 indicated that resident #031 has required the specified assistive device since admission to the resident's current resident home area, a specified period of time ago; based on an assessment completed by a member of the health care team.

The licensee failed to ensure that resident #031's plan of care was reviewed and revised to include the specified intervention (assitive device) following a reassessment. [s. 6. (11)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the ambulation equipment belonging to resident #031 and resident #018 were kept clean and sanitary.

i. On August 9, 2017, Inspector #655 observed the ambulation equipment of a specified type belonging to resident #031 to be unclean, with dried debris and small white particles on it. On August 14, 2017, Inspector #655 again observed the ambulation equipment belonging to resident #031 to be unclean. At the time of the second observation, resident

#031's ambulation equipment was observed to have white dust and debris on it. On August 15, 2017, Inspector #655 observed the ambulation equipment belonging to resident #031 to remain unclean.

Inspector #655 reviewed resident #031's current care plan. According to resident #031's care plan, resident #031 used two specified types of ambulation equipment; however, resident #031 preferred the use of one of the types of ambulation equipment (the type observed to be unclean by the Inspector) over the other, for a specified reason. In the same care plan, it is indicated that of the two types of ambulation equipment identified in the care plan, one was to be cleaned once weekly by night staff, in accordance with an established cleaning schedule. There was no information related to the cleaning of resident #031's preferred type of ambulation equipment in the care plan.

ii. On August 10, 2017, Inspector #592 observed the ambulation equipment belonging to resident #018 to be unclean, with dried debris on it. On August 14, 2017, Inspector #655 again observed the ambulation equipment belonging to resident #018 to be unclean. At the time of the second observation, resident #018's ambulation equipment was observed to have dust and dried debris on it. On August 15, 2017, Inspector #655 observed the same ambulation equipment belonging to resident #018 to remain unclean, with dried debris on it.

Inspector #655 reviewed resident #018's current care plan. According to resident #018's care plan, resident #018 required the use of ambulation equipment at all times. In the same care plan, it was indicated that resident #018's ambulation equipment was to be cleaned once weekly by night staff, in accordance with an established cleaning schedule.

During an interview on August 15, 2017, PSW #115 indicated to Inspector #655 that all resident ambulation equipment is to be cleaned by night staff (PSWs) in accordance with the established cleaning schedule, outlined in the "Night Duties Log". PSW #115 further explained, however, that day staff would clean a residents' ambulation equipment during the day shift if required.

During an interview on August 15, 2017, RPN #105 also indicated to Inspector #655 that night staff (PSWs) are expected to clean all resident ambulation equipment on a weekly basis. According to RPN #105, staff are expected to document the cleaning of resident ambulation equipment on the "Night Duties Log". RPN #105 indicated to Inspector #655 that an initial on the "Night Duties Log" is indicative that all resident ambulation

equipment belonging to residents who reside in the identified rooms were cleaned on the corresponding date. According to RPN #105, where there were no initials in the spaces provided on the "Night Duties Log" sheets, there was no way to determine when the resident's ambulation equipment had last been cleaned.

Inspector #655 reviewed the "Night Duties Log" for the resident home area of resident #031 which identifies the cleaning schedule by resident room number. According to the "Night Duties Log", resident #031's ambulation equipment was scheduled to be cleaned once a week. There was no documentation on the "Night Duties Log" sheets for the months of June, July or August, 2017, to indicate that resident #031's ambulation equipment had been cleaned at any time.

Inspector #655 reviewed the "Night Duties Log" for the resident home area of resident #018 for the month of August, 2017. According to the "Night Duties Log", resident #018's ambulation equipment was scheduled to be cleaned once weekly. When Inspector #655 reviewed the "Night Duties Log" sheet, there was no documentation to indicate that resident #018's ambulation equipment had been cleaned on a specified day that it was scheduled for cleaning during a specified week.

During an interview on August 22, 2017, ADOC #112 indicated to Inspector #655 that staff are expected to initial on the "Night Duties Log" to indicate that all pieces of resident ambulation equipment that correspond with the identified room numbers on a given day have been cleaned. At the same time, ADOC #112 observed that there were several gaps in the documentation on the night duties log sheets that were reviewed by the Inspector. [s. 15. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #025 is bathed, at a minimum, twice a week by the method of his or her choice.

During an interview, resident #025 indicated to Inspector #592 that he/she was not being bathed by the method of his or her choice.

During an interview, resident #025 indicated to Inspector #655 that he/she had not been bathed by the method of his or her choice for a specified period of four weeks. During the same interview, resident #025 indicated to Inspector #655 that during that specified four week period, he/she was bathed using a specified method that was not of his or her choice. At the time of the interview, resident #025 was unsure why he/she was being bathed by the specified method that was not of his or her choice.

Inspector #655 reviewed resident #025's current care plan and bathing schedule. According to the care plan, resident #025 was to be bathed by a specified method that was of his or her choice, and was to be bathed by the identified preferred method twice weekly. There was no indication in the care plan or bathing schedule that resident #025 required specialized equipment for bathing; and there were no other special instructions.

During an interview, PSW #125 indicated to Inspector #655 that resident #025 is bathed twice weekly; and that on one of those days, the resident was being bathed by a method of his or her choice; while, on the other day, an alternative method was being used. PSW #125 indicated to Inspector #655 that resident #025 could not be bathed by one of the available methods for a specific reason. PSW #125 indicated to Inspector #655 that he/she does not always work on the days that resident #025 is to be bathed by the method of his or her choice; and therefore, could not confirm that the resident was being bathed in accordance with his or her preferences on a weekly basis. PSW #125 indicated to Inspector #655 that when a resident is bathed, it is documented in Point of Care (POC); and that when a staff member documents that a resident has been bathed, they are prompted in POC to select the "bathing type" (tub bath, shower, or bed bath).

Inspector #655 reviewed the POC documentation for a specified one month period. According to the POC documentation, resident #025 had specifically been bathed by a method that was not consistent with his or her choice on at least one day during the specified one month period. According to the POC documentation, resident #025 was bathed on four other occasions in the same one month period; however, the method of

bathing was not specified for these additional dates. The entries on these days were made by PSW #122.

Inspector #655 reviewed the POC documentation with PSW #122 during an interview. PSW #122 indicated to Inspector #655 that on all dates when he/she had bathed resident #025 during the specified one month period, he/she had done so using a method that was not consistent with the resident's preferred method of bathing. That is, resident #025 had not been bathed in accordance with his or her preferences at any time during the specified one month period.

During the same interview, PSW #122 indicated to Inspector #655 that resident #025 prefers to be bathed by a specified method; and that sometimes resident #025 does not like the method that was being used throughout the specified one month period. PSW #122 indicated to Inspector #655, however, for a specified reason, resident #025 must go to another resident home area when the resident is to be bathed by the method of his or her choice. PSW #122 explained that for this reason, when they are short a PSW on the resident’s actual home area, it is easier to bathe the resident by an alternate method.

Over the course of the inspection, PSW #136 explained to Inspector #655 that resident #025 had been bathed by a specified method on another resident home area on a trial basis for a specific reason; however, PSW #136 indicated to Inspector #655 that there was no reason why resident #025 could not be bathed on the resident's own resident home area. PSW #136 indicated to Inspector #655 that after trialing the space on the other resident home area, it was determined that resident #025 preferred to be bathed on his/her own resident home area.

During an interview, RPN #105 indicated to Inspector #655 that resident #025 is expected to be bathed twice weekly by a specified method of his or her choice. RPN #105 indicated to Inspector #655 that resident #025 may be bathed using an alternate method if the resident refuses the specified method identified as being the resident's preference but is otherwise not scheduled to be bathed using that alternate method.

Over the course of the inspection, ADOC #112 identified resident #025's preferred method of bathing, according to his/her knowledge (which was not consistent with the alternate method that had been used during the specified one month period). According to ADOC #112, there were no special requirements for resident #025 related to bathing needs; and no reason why resident #025 could not be bathed by the method of his or her choice.

During an interview, ADOC #112 indicated to Inspector #655 that the alternate bathing method that had been used for resident #025 during the one month period is only to be used if it is the residents choice. ADOC #112 indicated to Inspector #655 that the bathing method used is not to be based on the preference of staff.

The licensee has failed to ensure that resident #025 is bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD has been consented to by the resident, or if the resident is incapable, the substitute decision-maker of the resident with authority to give that consent.

Resident #018 requires assistance with activities of daily living.

On a specified date during the inspection, resident #018 was observed to have three specified interventions in place while seated; including a specific device used to assist the resident with activities of daily living. The resident indicated to inspector #548 that the specified device was in use for two specific reasons.

On the same day, during an interview with the inspector, PSW #100 indicated that the resident requires that certain interventions be applied for safety reasons. PSW #100 indicated that the resident also uses one of the specified devices for a specific reason (related to activities of daily living); and that the device remains in place at all times, with three specific exceptions.

Over the course of the inspection, the resident was observed with the specified interventions in place; and to be using one of the specified devices for a specified activity of daily living.

RPN #135 indicated to Inspector #548 that the resident had consented to the use of the specified device; and, that it is mostly used to assist the resident in activities of daily living. RPN #548 indicated that the device it is to be removed otherwise.

Inspector #548 reviewed a Monitoring Flow Sheet in resident #018's health care record for a specified period, in the presence of PSW #136. On the Monitoring Flow Sheet, it was documented that a specified device was applied for the majority of the day, every day for resident #018.

Use of a Personal Assistance Service Device (PASD) in the home requires consent from the resident or Substitute Decision-Maker (SDM), with the approval of a legislatively identified regulated professional.

There was no documentation of consent or approval from the substitute decision maker to support the use of the specified device as a PASD for resident #018.

The licensee has failed to ensure that the use of a specified PASD had been consented to by resident #018 or resident #018's substitute decision-maker. [s. 33. (4) 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #018 received oral care.

During the inspection, Inspector #592 observed resident #018's mouth to have debris between the teeth.

Inspector #548 observed resident #018 a number of days later, at 1100 hours, to have foul breath when speaking to the inspector; and, there was thick yellowish-white debris to the base of the upper two front teeth and all along the lower teeth. The resident indicated that he/she had not been assisted with cleaning his/her teeth that morning. The resident was observed again at 1414 hours to have thick yellow-white debris to the upper and lower teeth gum line and on the upper portions of the top teeth.

During an interview, PSW #100 indicated to Inspector #548 that resident #018 requires assistance of a specified level to brush his/her own teeth, and that this level of assistance is to be provided to the resident as required.

The PSW flow sheets related to the oral care provided to resident #018 was reviewed by the Inspector. The records show that mouth care- which was to be provided twice daily, days and evenings- was not performed on a specified day; or on the evenings on four other specific occasions. On one day, it was recorded that care was provided; but it was not consistent with the resident's plan of care in that in the documentation on that day, a reference was made to the use of a specific aid that was not applicable to resident #018.

Resident #018's oral care was observed on three separate occasions. Each time, debris was observed on the teeth.

The licensee has failed to ensure that resident #018 received oral care. [s. 34. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every use of a physical device to restrain a resident under section 31 of the Act, the documentation includes the person who applied the device and the time of its application.

During the inspection, resident #001 was observed to have a physical safety device applied.

Resident #001 requires assistance with all aspects of activities of daily living due to his/her medical conditions. Over the course of the inspection, the resident was observed on several occasions at different times of day to be positioned also using a specified physical device.

The specified physical safety devices had a restraining effect.

The home's related policy, specifies that where such a device is used, all monitoring and repositioning shall be recorded on a specified monitoring form. A legend is provided for staff in the policy. Legend code 1 indicates that the physical safety device is on or the resident is repositioned.

The home's current process is to record on the Personal Support Workers (PSW)

flowsheets the type of device, when the device is on and repositioning.

A review of the resident's health care recorded was conducted. The PSW flow sheets for a specified period were reviewed. Missing on specified dates during the day is the documentation of the application and the time of the application of resident #001's physical safety device.

During an interview with Inspector #548, PSW #136 indicated that resident #001 is always positioned using a specified physical safety device. PSW #136 indicated that he/she observed that there was a lapse in the recording of every time a specified physical safety device was applied to resident #001, and who applied it. PSW #136 indicated that the home routinely completes audits of the documentation and that he/she will be conducting an audit related to the application of such physical devices. During an interview with Inspector #548 on the same day, the DOC indicated that he/she had also observed that there was a lack of documentation.

The licensee failed to ensure that the person who applied resident #001's physical safety device and the time of its application was documented. [s. 110. (7) 5.]

2. The licensee has failed to ensure that the documentation includes the resident's response to the physical device.

During the inspection, resident #001 was observed to be seated with a physical safety device in place.

Resident #001 requires assistance with all aspects of activities of daily living due to his/her medical conditions. Resident #001's Substitute Decision Maker (SDM) and physician have approved of the use of a specified safety device while the resident is seated in a specified manner.

The home's related policy specifies that it is the responsibility of the nursing and personal care staff to record and document the resident's response (to the device).

The home's current process is to record on the Personal Support Workers (PSW) flowsheets the type of device and when applied; and, on the residents' electronic Medication Administration Record, the every eight hour assessment and monitoring of residents with applied physical devices.

A review of the resident's health care recorded was conducted.

During an interview with inspector #548, the Director of Care (DOC) indicated that registered nursing staff are to monitor, observe and assess the resident with when such a physical device is in use for a resident every 8 hours. The DOC indicated that documentation of this is recorded in the individual resident electronic Medication Administration Record. The DOC further indicated that the home changed their documentation to an electronic format; and from his/her review of the documentation, there was no record of resident #001's response to the use of the physical device.

The licensee has failed to ensure that resident #001's response to the applied physical device was documented. [s. 110. (7) 6.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On August 8, 2017, at 0920 hours, Inspector #548 observed on the first floor north wing a medication cart in the hallway, unattended. On top of the cart, there were several specified medications, including medications belonging to resident #041and resident #012; and a medication cup that contained a mixture of jam and a crushed medication that was white in colour.

At the same time, the inspector observed a resident moving towards the medication cart.

Registered Nurse (RN) #102 indicated to the Inspector that he/she was aware that medications were not to be left unlocked; however, he/she had assisted a staff member with a resident. RN #102 explained that the mixture of jam contained a crushed medication for resident #042.

On the same day, in the first floor spa room, Inspector #548 observed two containers, each containing a specified prescribed medication for resident #007 to be resting on the back of the toilet seat. Resident #007 currently resides on a different floor.

On August 8, 2017, Inspector #548 observed on the first floor at resident #001's bedside table, two prescription medications.

During an interview on the same day with the inspector, RN #103 indicated that all prescriptive medication of a specified type are kept in the treatment room. RN #103 explained that Personal Support Workers are provided the drug by the registered nursing staff member to apply and then they are to return the prescription to the registered nursing staff member once completed. RN #103 indicated that these types of prescriptive medications are to be kept secure and locked in the treatment room.

The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (b)]

Issued on this 9th day of November, 2017

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

Original report signed by the inspector.