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

Division des foyers de soins de longue durée
Inspection de sions 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
Oct 18, 2016	2016_267528_0020	028516-16	Resident Quality Inspection

Licensee/Titulaire de permis

DEEM MANAGEMENT SERVICES LIMITED
2 QUEEN STREET EAST SUITE 1500 TORONTO ON M5C 3G5

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

HAMILTON CONTINUING CARE
125 WENTWORTH STREET SOUTH HAMILTON ON L8N 2Z1

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

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

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 22, 23, 26, 27, 28, 29, 30, 2016

This inspection was done concurrently with Complaint Inspection Log #’s: 014048-15 related to financial abuse and accommodation, 025209-15 related to continence care, 029038-15 and 001550-16 related to plan of care, 009291-16 related to abuse, 029334-16 related to neglect and Critical Incident System Inspection Log #: 019662-16 related to abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Minimum Data Set Resident Assessment Instrument (MDS RAI) Coordinator, Food Service Manager (FSM), Activation/Environmental Manager, Office Manager, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), health care aides, activity staff, maintenance worker, housekeeping staff, laundry staff, dietary staff, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

12 WN(s)
6 VPC(s)
1 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. 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 the residents were not neglected by the licensee or staff.

A. On an identified day in September 2016, resident #016 reported to registered staff and direct care staff that they needed to be toileted. Interview with the resident revealed that the resident had waited too long, was upset and frustrated, as a result, was incontinent of bowels. The resident also stated that they often had to wait for staff to be available to assist them to the toilet. The resident was not toileted until over two hours after initial request.

i. The Minimum Data Set (MDS) Assessment from 2016, identified that the resident was occasionally incontinent of bowels and frequently incontinent of bladder. The plan of care directed staff to offer toileting to the resident before and after meals and as needed using a lift.
ii. For approximately two hours, registered staff was observed administering medication and feeding resident; direct care staff were observed assisting resident's to and from the dining room, feeding residents, socializing with residents, completing documentation and toileting residents.
iii. Staff entered the resident's room four times after the resident asked to use the toilet, and the resident was not toileted.
iv. Interview with registered staff #100 and direct care staff #103 confirmed they were aware the resident was waiting to be toileted.

As a result of the staff's inaction to toilet the resident, the resident reported to LTC Homes Inspector #528 that they were upset and sore and had altered skin integrity as assessed by registered staff. The staff neglected to toilet the resident for over two hours after the resident's initial request causing the resident frustration, pain, and discomfort.

B. The licensee failed to ensure that resident's were protected from abuse from PSW #116.

i. In late 2015, while providing continence care to resident #084, PSW #115 overheard PSW #116 say inappropriate comments to resident #084. In an interview with PSW #115, it was identified that the incident was reported immediately; however, felt the home did not do anything to protect the resident. Interviews with the Administrator revealed that PSW #116 was disciplined. PSW #116 confirmed they were disciplined as a result of the incident and that that they continued to care for the resident until they deceased in 2016.

ii. In June 2016, it was reported that PSW #116 was rough with resident #083 and stated inappropriate comments. Interviews with resident #083 and Critical Incident System reports confirmed that as a result the resident refused to receive care by PSW #116. As a result of the incident, the home determined that PSW #116 would no longer provide care to resident #083, PSW #116 was disciplined. Interviews with resident #083 and PSW #115 confirmed that approximately one month after the incident, PSW #116 began providing care to the resident. Interview with resident #083 confirmed that they did not consent to PSW #116 proving care, which made them upset.

iii. Interview with the Administrator identified that they had been in the role since July 2013 and were aware of PSW #116's history of failing to provide residents with adequate care or may have jeopardized their safety and well-being; however, explained that since July 2013, the PSW #116 was disciplined per the collective agreement progressive discipline schedule.

Although PSW #116 had a history of failing to provide residents with adequate care or may have jeopardized their safety and well-being, consistent discipline had not been documented on file until the end of 2015. Noting ongoing concerns, PSW #116 continued to provide care to resident #083 and #084; and therefore residents were not protected from abuse. (585) (528) [s. 19. (1)]

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 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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. In June 2016, resident #011 was readmitted from the hospital with a recurring area of altered skin integrity reopened. Review of the plan of care did not include weekly assessment for two weeks in June and July 2016. Interview with the Wound Care Coordinator confirmed that the resident had a recurring area of altered skin integrity and that weekly assessments were not completed for two weeks in June and July 2016. (528)

B. The plan of care for resident #016 identified that the resident was at high risk for altered skin integrity with recurring areas of altered skin integrity that were not consistently assessed on a weekly basis.

i. In October 2015, a new area of altered skin integrity was documented by registered staff. Review of the plan of care did not include weekly assessments for three weeks from October to November 2015.
ii. In February 2016, two new areas of altered skin integrity were documented in the progress notes by registered staff requiring treatment; however, the plan of care did not include weekly assessments of the areas.

Interview with the WCC confirmed that weekly assessments were not consistently completed for resident #016 when the resident had areas of altered skin integrity requiring treatment, in October and November 2015, and February 2016. (528) [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

WN #3: 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).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(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).

Findings/Faits saillants :

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

A. The plan of care for resident #016 identified that the was occasionally incontinent of bowels and frequently incontinent of bladder. The plan outlined that the resident requested to be toileted and also directed staff to offer toileting before and after meals and as needed using lift. On two different days in September 2016, the staff were not observed offering the resident to toilet before and after meals but instead waiting for the resident to call for assistance. Interview with registered staff #100 and direct care staff #102 and #103 confirmed that they assisted the resident with toileting when they requested, and therefore, the resident's individualized plan to promote and manage

bowel continence was not implemented. (528)

B. On an identified day in September 2016, resident #020 was observed seated in the lunch room from approximately three hours, at which time the resident was provided assistance with toileting when leaving the dining room. The MDS Assessment from 2016, identified that the resident was frequently incontinent of bladder and usually continent of of bowel. The plan of care directed staff to toilet the resident when they get up before lunch and after supper, with one staff. Interview with direct care staff #102 and #103 confirmed that the resident was toileted before breakfast and after lunch. The staff did not implement the resident's plan of care for toileting. (528) [s. 51. (2) (b)]

2. The licensee failed to ensure that the resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

On an identified day in September 2016, resident #016 reported to registered staff and direct care staff that they needed to be toileted.
i. The Minimum Data Set (MDS) Assessment from 2016, identified that the was occasionally incontinent of bowels and frequently incontinent of bladder. The plan of care directed staff to offer toileting to the resident before and after meals and as needed using a sit to stand lift.
ii. Interview with resident revealed that the resident had waited too long and, as a result, was incontinent. The resident also stated that they often had to wait for staff to be available to assist them to the toilet.
iii. Observed the provision of care on the until until the resident was toileted over two hours, after their initial request.
iv. For an hour registered staff was administering medications, at which time, they proceeded to the dining room to feed resident's their beverages. Registered staff entered the resident's room twice during that time frame, and the resident was not toileted.
v. Both direct care staff were observed to be back from break. For approximately twenty-five minutes, direct care staff was observed asking all residents choice for meals, feeding residents beverages, charting on the computer, and sitting and talking with resident's in the dining room.
vi. Direct care staff #103 entered the resident's room three times during that time frame, and the resident was not taken to the toilet.
vii. Interview with registered staff #100, confirmed they were aware the resident had to go to the bathroom before staff had returned from break and had communicated the request

to the direct care staff. Interview with direct care staff #103 confirmed that the resident would not be toileted until after lunch, as all staff had to take breaks before lunch, and then they could not leave the dining room during lunch service. (528) [s. 51. (2) (c)]

3. The licensee failed to ensure that residents were provided with a range of continence care products that were based on their individual assessed needs.

The plan of care for resident #082 identified that the resident was incontinent at times, was able to toilet themselves independently, and wore a large continent product with inserts. The resident stated they used a continent product and the home provided them with the insert, and the insert was replaced when the resident was incontinent. Interview with staff#118, who confirmed that the resident wore large continent products with an insert to ensure the resident was kept dry for longer periods of time. Instead of the home providing the resident with more large continent products or a more absorbent type of pull up product, they placed the resident in large continent product and insert; therefore not provided with a continent product that was based on their individual need. (528) [s. 51. (2) (h) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
i. that the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that plan is implemented.
ii. that the resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence.
iii. that residents are provided with a range of continence care products that are based on their individual assessed needs., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A. Resident #012 was observed sitting in their tilt wheelchair which was in the tilted position on multiple days during the course of this inspection. Registered staff #106 stated they were positioned in their tilt wheelchair for positioning and comfort and to assist them with activities of daily living. Review of the plan of care indicated there was no documented assessment for the use of the tilt wheelchair as a PASD, nor any documented consent or approvals for its use. Registered staff #106 confirmed that the tilt wheelchair was not assessed as a PASD, nor did they have documented consent or approval for its use.

B. On September 29, 2016, resident #012 was observed in bed with two assist rails raised in the guard position. Registered staff #120 stated they required both bed rails to assist with bed mobility, prevent risk of falling and safety. Review of the plan of care did not include a documented assessment to determine the reason for the use of the bed rails, nor any documented approvals or consent for their use. Registered staff #120 confirmed the resident was not assessed to determine if the bed rails were being used as a PASD or a restraint nor did they have documented consent or approval for the device in place.

C. Review of the written plan of care for resident #017 indicated they required half bed rails raised for turning and repositioning. During the course of this inspection, their bed was observed with one bed rail raised in the guard position. Interview with registered staff #120 and PSW #105 stated they required one bed rail raised to assist with turning, repositioning and to prevent risk of falling. Review of the plan of care revealed there was no documented assessment for the use of the bed rail as a PASD, nor any documented consent or approvals for its use. Registered staff #120 confirmed that the resident was not assessed to determine if the bed rail was being used as a PASD or a restraint nor did they have documented consent or approval for the bed rail in place. [s. 33. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living is included in a resident’s plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD has been considered and tried where appropriate.
3. The use of the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD 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., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. Throughout the course of the inspection, resident #016 was observed to require the assistance of two direct care staff for toileting using a sit to stand lift. Review of the plan of care identified that in September 2016, a Lift and Transfer Assessment completed by registered staff, noted that they required three person total assist for toileting using a sit to stand lift. Interview with direct care staff #102 and #103 confirmed that they used two staff with a sit to stand lift to toilet the resident, and three persons had not been required in some time. Furthermore, on day and evening shifts the floor was staffed with two direct

care staff and one registered staff only. Interview with RN #100 confirmed that the resident required three persons; however, did not assist two direct care staff in the transfer of the resident on two separate observations. The Lift and Transfer Assessment completed by registered staff in September 2016, was not consistent with the assessment and care provided to the resident by direct care staff on a daily basis. (528)

B. In August 2016, the Minimum Data Set (MDS) Assessment for resident #015 identified that the resident had no change in behaviours when compared to the last assessment. The Resident Assessment Protocol (RAPS) for the same time period stated that the resident had shown an improvement in behaviours. However, review of behaviour documentation revealed that the resident had an increase in responsive behaviours. Interview with registered staff #119 confirmed that the MDS, RAPS, and daily care assessments for resident #015 were not consistent with each other for behaviours in August 2016. (528) [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #040 was admitted to the home in 2015, with specific pain medication. Review of the physician orders identified a new pain medication was ordered the following day, as needed to help control their pain. One week later, the resident was complaining of increased pain, another pain medication was ordered to be administered twice a day and their original pain medication was discontinued. Review of the home's policy "Physician/Prescriber Orders", dated September 2010, identified that registered staff were to complete the following tasks related to processing an order which included but was not limited to, informing the SDM of the new product or procedure being prescribed. Interview with registered staff #100 confirmed that resident #040's pain medication was changed several times and the SDM was not informed of the new orders prescribed to address the resident's pain, therefore the SDM was not given an opportunity to fully participate in the development or implementation of resident #040's plan of care. [s. 6. (5)]

3. The plan of care was not provided to the resident as specified in the plan.

On and identified day in September 2016, at approximately 1115 hours, resident #016 was observed seated in their wheelchair with therapy applied; however the therapy was

turned off. Review of the plan of care for the resident identified that they required therapy daily. Interview with registered staff #100 confirmed that the resident was to have therapy applied daily but it was not turned on and therefore,the resident was not receiving any therapy as required in their plan of care. [s. 6. (7)]

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

A. Review of resident #012's plan of care identified they walked with extensive staff assistance from their bed to the bathroom. Interview with PSW #108 stated the staff were no longer walking. Interview with registered staff #106 confirmed the resident was no longer walking with staff or with the physiotherapist and the plan of care was not revised when the care set out in the plan was no longer necessary.

B. Review of the plan of care for resident #012 identified they were transferred with extensive assistance of two for toileting. Interview with PSW #115 stated the resident was transferred with the sit to stand lift for toileting. Interview with registered staff #106 stated the resident was no longer transferred with two staff and now required a mechanical lift to get on and off the toilet and confirmed the written plan of care was not revised when their care needs changed.

C. Review of the plan of care for resident #017 identified they walked with assistance of two staff from their bedroom to the dining room. Interview with PSW #105 stated the staff were no longer walking the resident. Interview with registered staff #106 confirmed the resident was no longer walking with staff and the plan of care was not revised when the care set out in the plan was no longer necessary

D. The plan of care for resident #017 was reviewed and revealed they were transferred with two staff for all transfers. Interview with PSW #105 stated the resident was no longer transferred with two staff and required the sit to stand lift for all transfers. Interview with registered staff #106 confirmed the resident required the sit to stand lift for all transfers and the written plan of care was not revised related to their transferring needs.

E. Resident #017 was observed during the course of this inspection positioned in a tilted wheelchair. Review of the plan of care for resident #017 indicated that were positioned in a tilt wheelchair but the tilt was not required. Interview with PSW #105 stated the

resident was tilted in their wheelchair as they would slide forward and needed to be repositioned by tilting the wheelchair. Interview with registered staff #106 stated the resident required their wheelchair to be tilted for repositioning and comfort and confirmed the written plan of care was not revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that following:
i. staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
ii. care is provided to the resident as specified in the plan of care.
iii. that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home’s Director of Nursing and Personal Care worked regularly in that position on site tn a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.

During the course of the inspection, the Administrator of the home also held the role of Director of Care. In an interview with the Administrator/Director of Care (DOC) a total of 75 hours every two weeks; 43 hours as DOC and 32 hours as the Administrator. In the interview they also identified they worked solely as the Administrator/DOC since October 2015; and was aware they did not meet the legislative requirements for hours worked as a Director of Care in a home licensed for 64 beds. [s. 213. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home’s Director of Nursing and Personal Care works regularly in that position on site tn a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week., to be implemented voluntarily.

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 and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices included a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003",created by the Federal Food and Drug Administration, which outlined that decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized patient assessment using an interdisciplinary team with input from the patient and family or the patient's legal guardian. Furthermore, the document detailed guidelines for bed system evaluation and testing for potential zones of entrapment.

A. During the course of the inspection, resident #014 was observed in bed with the bed rail on the side of the bed raised in the guard position and the bed rail on the other side of the bed raised in the transfer position. Review of the MDS assessment in April and July 2016, identified that no bed rails were used. Interview with PSW #117 stated the resident required the bed rails to assist with transfers and bed mobility. Review of the plan of care revealed that an assessment of bed rail use using the home Bed Rail and Entrapment Risk Assessment was not completed and this was confirmed by registered staff #100.

B. During the course of the inspection, resident # 012 was observed in bed with both rails raised in the guard position. Review of MDS assessment completed in July 2016, indicated they used bed rails daily and review of the plan of care identified that an assessment of bed rail use using the home's Bed Rail and Entrapment Risk Assessment was not completed. Interview with PSW #118 stated that both bed rails were raised when they were in bed for safety and to prevent risk of falling. Registered staff #106 confirmed the resident required bed rails raised when in bed and a bed rail risk assessment was not completed for the use of their bed rails.

C. Resident #017's bed was observed with one bed rail raised in the guard position during the course of this inspection. Interview with PSW #105 stated the resident had one bed rail raised in the guard position when in bed to assist with turn and repositioning and for safety to prevent risk of falling. Review of the plan of care identified they required half bed rails for turning and repositioning; however, did not include an assessment for bed rail use using the home's Bed Rail and Entrapment Risk Assessment. Interview with registered staff #106 stated they required one bed rail raised when in bed and confirmed

that the bed rail assessment was not completed for the use of their bed rails.

D. During the course of the inspection, resident #041 was observed in bed with the bed rail on one side of the bed raised in the transfer position and the bed rail on the other side of the bed raised in the guard position. Review of the plan of care identified that an assessment of bed rail use using the home's Bed Rail and Entrapment Risk Assessment was not completed prior to the start of this inspection. Interview with PSW #103 stated they had both rails raised to assist with transfers and bed mobility. Registered staff #120 confirmed the resident required both bed rails raised and the bed rail risk assessment was not completed.

Review of the Bed Entrapment worksheet from an identified date it 2016 outlined that resident #041 was sleeping on an air mattress; however, observation of their bed system revealed they had a regular mattress. Interview with maintenance staff who tested the bed system for zones of entrapment in the home stated that when resident #041 was admitted in April 2016, the air mattress was removed, replaced with a regular mattress and confirmed that the bed system was not evaluated for zones of entrapment to minimize the risk. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that were bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices, to minimize the risk to the resident., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observation of the enclosed patio, the first floor and third floor dining rooms revealed they did not have a resident-staff communication and response system and this was confirmed by the Administrator. [s. 17. (1) (e)]

WN #9: 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).

Findings/Faits saillants :

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

The policy "RC-02-01-02 Zero Tolerance of Resident Abuse and Neglect:Response and Reporting", last revised January 2016, directed all staff to report and alleged, suspected or witnessed resident incident abuse or neglect to the Administrator or most senior supervisor of the home and report the allegations to the Ministry of Health and Long Term Care through the Action Line.

A. In December 2015, PSW #115 observed PSW #116 make inappropriate comments to resident #084 while providing care. During the course of the inspection, an interview with PSW #115 confirmed that the allegations were immediately reported to the Administrator. Interview with the Administrator/DOC confirmed the allegations; however, also confirmed that the information was not reported to the Ministry of Health and Long Term Care.

B. In February 2016, while using the home's resident outdoor space, an altercation occurred between resident #082, resident #080 and their visitor. The plan of care included documented the incident and identified that PSW staff #102 observed the incident. The confrontation was immediately reported the Administrator. Interviews with resident #082 and the Administrator confirmed the altercation; however, it was not reported to the Ministry of Health and Long Term Care. (528) [s. 20. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that if there was no Family Council, the licensee convened semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council.

It was identified during the course of the inspection, that the home did not have a Family Council. Interview with two resident's substitute decision makers confirmed that they would be interesting in attending Family Council meetings, which had been communicated to front line staff and the office manager. Interview with the Administrator and Programs Manager identified that the home sent out a letter to families once per year, stating that if families had interest in Family Council, they were to contact the Programs Manager; and confirmed that they did not hold semi-annual meetings to advise families of their right to establish a Family Council.   (528) [s. 59. (7) (b)]

WN #11: 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 and implemented for cleaning of the home, including resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

The home's policy "HL-05-03-01 A1:Recommended cleaning frequencies", dated September 2015, identified the following areas to be cleaned daily: resident room, resident washrooms, nursing stations/med rooms, lounge areas, activity/craft areas, therapy rooms, utility rooms, kitchenettes, tubs/spas rooms, dining rooms, serveries, trash/garbage collection, public/staff washrooms, main entrance, staff lunch rooms.

Review of the home's Housekeeping/Laundry Aide Routines and Housekeeping staff schedule, revealed that only one housekeeper was scheduled to work on weekend days. The job routine directed the cleaning staff to only clean rooms that are soiled and if residents were awake. Interviews with housekeeping staff #112 confirmed that on weekends the housekeeper scheduled is unable to clean all of the areas recommended to be cleaned daily in the home's policy. (528) [s. 87. (2) (a) (i)]

WN #12: 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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received training annually in accordance with O. Reg 79/10, s. 221 (1) 6 for staff who apply or monitor residents with PASD’s, training in the application, use and potential dangers of the PASD’s.

Education records provided by the home indicated 73 percent (%) of direct care staff received training in Minimizing and Restraining education in 2015. Interview with the Administrator/DOC and Office Manager confirmed only 73% of direct care staff received mandatory training for Minimizing of Restraints in 2015. . [s. 221. (1) 6.]

Issued on this 26th day of October, 2016

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

Original report signed by the inspector.

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2016_267528_0020
Log No. / Registre no:	028516-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 18, 2016
Licensee / Titulaire de permis :	DEEM MANAGEMENT SERVICES LIMITED 2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5
LTC Home / Foyer de SLD :	HAMILTON CONTINUING CARE 125 WENTWORTH STREET SOUTH, HAMILTON, ON, L8N-2Z1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Enesia Malapela

To DEEM MANAGEMENT SERVICES LIMITED, 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. 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 ensure that all residents, including but not limited to resident #016 and #083, are protected from abuse by anyone and are not neglected by the staff by completing the following:
i. that all staff receive retraining on the home's policy Prevention of Abuse and Neglect including Mandatory Reporting and Whistleblowing Protection, and the Resident Bill of Rights
ii. that PSW #116 and any other staff with a history of allegations of abuse and/or neglect are closely monitored, and actions taken, as appropriate to ensure that all residents are protected by the home
iii. that any monitoring of staff or actions taken as a result of allegations of abuse or neglect are documented
iv. a follow up is conducted at regular intervals determined by the home with residents #016 and #083 to ensure that they feel safe and cared for in a manor that supports their health and well-being, and that the follow-up is documented

Grounds / Motifs :

1. The non-compliance issued was determined to have a severity of 'actual harm/risk' with a scope of 'isolated'.

The licensee failed to ensure that the residents were not neglected by the licensee or staff.

A. On an identified day in September 2016, resident #016 reported to registered staff and direct care staff that they needed to be toileted. Interview with the resident revealed that the resident had waited too long, was upset and frustrated, as a result, was incontinent of bowels. The resident also stated that they often had to wait for staff to be available to assist them to the toilet. The

resident was not toileted until over two hours after initial request.

i. The Minimum Data Set (MDS) Assessment from 2016, identified that the resident was occasionally incontinent of bowels and frequently incontinent of bladder. The plan of care directed staff to offer toileting to the resident before and after meals and as needed using a lift.
ii. For approximately two hours, registered staff was observed administering medication and feeding resident; direct care staff were observed assisting resident's to and from the dining room, feeding residents, socializing with residents, completing documentation and toileting residents.
iii. Staff entered the resident's room four times after the resident asked to use the toilet, and the resident was not toileted.
iv. Interview with registered staff #100 and direct care staff #103 confirmed they were aware the resident was waiting to be toileted.

As a result of the staff's inaction to toilet the resident, the resident reported to LTC Homes Inspector #528 that they were upset and sore and had altered skin integrity as assessed by registered staff. The staff neglected to toilet the resident for over two hours after the resident's initial request causing the resident frustration, pain, and discomfort.

B. The licensee failed to ensure that resident's were protected from abuse from PSW #116.

i. In late 2015, while providing continence care to resident #084, PSW #115 overheard PSW #116 say inappropriate comments to resident #084. In an interview with PSW #115, it was identified that the incident was reported immediately; however, felt the home did not do anything to protect the resident. Interviews with the Administrator revealed that PSW #116 was disciplined. Interview with PSW #116 confirmed they were disciplined and that they continued to care for the resident until they deceased in 2016.

ii. In June 2016, it was reported that PSW #116 was rough with resident #083 and stated inappropriate comments. Interviews with resident #083 and Critical Incident System reports confirmed that the incident, made them upset and the resident refused to receive care by PSW #116 after the incident.
As a result of the incident, the home determined that PSW #116 would no longer provide care to resident #083, PSW #116 was disciplined. Interviews with resident #083 and PSW #115 confirmed that approximately one month after the

incident, PSW #116 began providing care to the resident, including but not limited to, continence care. Interview with resident #083 confirmed that they did not consent to PSW #116 proving care and did not want them proving care.

iii. Interview with the Administrator identified that they had been in the role since July 2013 and were aware of PSW #116's history of failing to provide residents with adequate care or may have jeopardized their safety and well-being; however, explained that since July 2013, the PSW #116 was disciplined per the collective agreement progressive discipline schedule.

Although PSW #116 had a history of failing to provide residents with adequate care or may have jeopardized their safety and well-being, consistent discipline had not been documented on file until the end of 2015. Noting ongoing concerns, PSW #116 continued to provide care to resident #083 and #084; and therefore residents were not protected from abuse. (585) (528) [s. 19. (1)] (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 16, 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 18th day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

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