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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Feb 8, 2016	2015_240506_0030	035240-15	Resident Quality Inspection

Licensee/Titulaire de permis

IDLEWYLD MANOR
449 SANATORIUM ROAD HAMILTON ON L9C 2A7

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

IDLEWYLD MANOR
449 SANATORIUM ROAD HAMILTON ON L9C 2A7

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

LESLEY EDWARDS (506), CAROL POLCZ (156), CATHY FEDIASH (214), GILLIAN TRACEY (130), LISA VINK (168), MELODY GRAY (123)

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): December 18, 21, 22, 23, 2015 and January 4, 5, 6, 7, 8, 12, 13, 14, 15, 18, 19, 20 and 21, 2016.

During this inspection the inspections listed below were conducted concurrently:

Complaints

004807-14 - related to skin and wound care, nutrition and hydration and falls management.
009066-14 - related to abuse, reporting certain matters to the Director and infection control.
019114-15 - related to access to plan of care, resident's bill of rights and positioning.
004670-15 - related to bathing, continence care and assistance.
028586-15 - related to resident's bill of rights, complaints procedure and nursing support services.

Critical Incident Reports

007989-14 - related to abuse and neglect.
009951-14 - related to responsive behaviours.
001713-15 - related to fall prevention and management.
001976-15 - related to fall prevention and management.
026873-15 - related to resident to resident responsive behaviours.
026959-15 - related to resident to resident responsive behaviours.
028501-15 - related to restraints.
031788-15 - related to abuse and neglect.
014981-15 - related to resident to resident responsive behaviours and fall prevention and management.
016584-15 - related to resident to resident responsive behaviours.

Inquiries that were conducted while at the home.

009981-15 - related to fall prevention and management.
013976-15 - related to fall prevention and management.
015197-15 - related to fall prevention and management.
017191-15 - related to fall prevention and management.
025666-15 - related to fall prevention and management.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Administrative Assistant, the Director of Care (DOC), Nursing Administrative Assistant, registered nursing staff, personal support workers

(PSW's), Food Services Manager (FSM), Dietitian (RD), dietary staff, laundry and housekeeping staff, Manager of Recreation and Volunteer Services, recreation staff, Resident Assessment Instrument Co-ordinator (RAI), families and residents.

During the course of the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures and resident health records and conducted interviews.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
17 WN(s)
11 VPC(s)
3 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

s. 6. (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 the written plan of care for each resident sets out clear directions to staff and others who provided direct care to the resident.

A. The plan of care for resident #020, including both the care plan and resident’s kardex, indicated that the resident preferred a certain method of bathing. In an interview with the resident they confirmed that they would prefer a different method of bathing. On the home’s bath and shower schedule it also indicated the resident’s preferred bathing method. It was confirmed with PSW staff the resident at times does receive both

methods of bathing and the written plan of care did not set out clear direction to staff who provided direct care to the resident. (506)
B. The plan of care for resident #082, including the electronic medication administration record (eMAR), indicated that the resident was to have their medications whole in applesauce. During observation of the medication pass on an identified date in January 2016, the resident was given their scheduled medications crushed in applesauce. Registered staff #103 confirmed that the resident always received their medications crushed and that the eMAR record had not been changed to reflect this; therefore the resident’s plan of care did not provide clear direction to staff who provide direct care to the resident.
C. The written plan of care for resident #021 currently in place to direct staff, indicated that the resident required the use of a lift. The same plan, indicated the resident was able to ambulate with the use of their walker; for psychotropic drug use staff were to observe the resident’s gait. The plan identified the resident was at risk for falls; encourage resident to use their walker; do not restrain the resident; however, the plan identified the resident required a seat belt restraint in place. The DOC confirmed the written plan of care did not provide clear directions to staff providing care.(130). [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A. Resident #031 had an assessment completed on an identified date in May 2015, regarding their needs at meal times. The home, with the support of the family, made a decision related to where the resident would be served and eat their meals. A review of the plan of care under the focus statement of eating identified that the resident ate their meals in the unit dining room. The plan of care identified that the resident was to be served promptly at mealtime and if the resident was displaying responsive behaviours staff were to provide meals in a quiet side of the dining room or in the resident's own room. Interview with the DOC confirmed that the resident did not eat meals in the dining room. The DOC confirmed that the resident's plan of care was not based on the assessment of the resident nor their needs.
B. Resident #023 was observed on two occasions, resting in bed, with a bed rail in the raised position on the left side and a small rail raised on the right side of the bed. Interview with registered staff #128 and #129 and the resident confirmed that the resident used both rails on a consistent basis. A review of the Restraint Reassessment, identified the use two bed rails in the raised position when in bed; although, did not specify the type of rails in use. The plan of care identified, under the focus statement of falls, to have the

bed rail closests to the window up for use in bed mobility and safety and made no mention of the second small rail which was used by the resident. Registered staff #128 and #129 confirmed that the plan of care was not based on the assessment of the needs and preferences of the resident.(#168) [s. 6. (2)]

3. 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.

Resident #074 was identified by staff and in the clinical record as a risk for falls. The resident sustained an injury as a result of a fall between the Minimum Data Set (MDS) assessments completed on an identified date in April 2015 and July, 2015. The MDS coding completed during the assessment completed in July 2015, identified that the resident sustained a fall in the past 31 to 180 days; however, did not identify an injury in the last 180 days. Interview with registered staff #138 confirmed that the resident sustained an injury, from a fall, during the past 180 days and that this was not included in the July 2015, MDS coding, as required. The assessments completed were not integrated, consistent with nor complemented each other. [s. 6. (4) (a)]

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. The written plan of care for resident #021 indicated that the resident required the use of a certain mechanical device as the resident was unable to weight bear; required a device to assist with ambulation, was incontinent and wore product brought in by family; for psychotropic drug use staff were to observe the resident's gait and ability to position and turn; and exhibited an identified responsive behaviour. Staff #108 and #112 confirmed the resident no longer required the use of the mechanical lift, but used a different mechanical lift; no longer used the device for ambulation, but required a different device for mobility, because the resident no longer ambulated; and no longer wore the specified product, but required a different product for incontinence and no longer exhibited the specified responsive behaviour. The plan of care was not revised when the resident's care needs changed and when interventions in the plan were no longer necessary. This non-compliance was identified as a result of Critical incident inspection #028501-15, which was conducted simultaneously with the RQI. (Inspector #130).
B. Resident #021 was admitted to the home in August 2015. The day following admission, a progress note indicated the resident was demonstrating a responsive

behaviour and for safety staff applied a device. This same day a second progress note indicated that the resident verbalized thoughts that were of safety concern. The following day a progress note indicated the resident set off an alarm and checks were required. Three days after admission a fall intervention was placed next to the resident's bed which was in the lowest position and another safety device implemented as a result of a fall. Two days later staff observed the resident trying to remove the device, therefore the device was removed and placed on another area of their body. Later that month one to one staff was implemented and two days later staff documented that resident was placed in a device for unsteadiness. The following month in October 2015, registered staff documented that the resident was placed in the device with a seat belt and the seat belt had slid to an unsafe position.

The written plan of care was not reviewed and revised when there were changes to the care needs of the resident Interview with the DOC confirmed that the plan of care was not reviewed and revised with the identified changes in the care needs for the resident. (Inspector #130)

C. Resident #016 was newly admitted to the home and was experiencing responsive behaviours. Resident #016 had 12 documented incidents of responsive behaviours or altercations involving co-residents and staff during a 27 day time period in December 2014. The document that the home refers to as the care plan was not revised to include the responsive behaviours or the interventions to manage these behaviours. The DOC confirmed that the care plan was not revised to include the resident's responsive behaviours. (inspector #506)

D. Over a three day time period in August 2015, resident #029 had six documented reports to their clinical record that indicated that the resident was having newly identified pain. During this time the resident was spending more time in bed and requesting pain medications. The physician was not informed of the change in the resident's status until three days later in August, 2015, when the physician ordered the home to complete a x-ray which identified medical concerns. The DOC confirmed that the home did not review and revise the resident's plan of care when the resident's care needs changed. (inspector #506)

E. A review of the clinical record for resident #030 indicated that on an identified date in August 2014, the resident was leaning to the side and that they would monitor the resident. There was no further indication that the resident was monitored, or an assessment of the resident's change in condition completed. The resident's plan of care was not reviewed and revised when the resident's care needs changed. This was confirmed with the DOC on an identified date in January 2016. (inspector #156) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 written plans of care set out clear directions to staff and to ensure that plans of care are based on the assessed needs of the resident and the plans are integrated, consistent and compliment each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum an interdisciplinary assessment of the following with respect to the resident, safety risks.

Resident #031 was reported to display a medical event on three occasions over a six month period, each which were reported to the physician. Interview with the resident's

family, at the time of the first known incident, identified that this type of event had occurred in the past. Staff interviewed were aware of the symptoms displayed by the resident related to the incidents and verbalized actions to be taken; however, the plan of care did not include information regarding this safety risk as confirmed during a review of the plan of care by registered staff member #116, who identified that based on the frequency of the incidents this need should be included in the plan of care. [s. 26. (3) 19.]

2. The licensee failed to ensure the plan of care was based on, at a minimum, an interdisciplinary assessment of sleep patterns and preferences.

A. A review of resident #027’s plan of care did not include the resident’s sleep and rest patterns or preferences. An interview with PSW #105 confirmed that the resident gets up by the night staff. The RAI Co-ordinator confirmed the resident’s sleep patterns and preferences were not assessed or documented in the plan of care. (506)
B. During stage 1 of the RQI resident #014 indicated that they wanted to get up earlier in the morning. A review of the resident's current plan of care indicated what time the resident liked to go to bed and when to get up. A review of the “Admission Checklist” document, asked under sleep/rest patterns the time that the resident liked to wake up and the time that the resident liked to go to bed; however; only the question that asked what time the resident liked to go to bed was answered. The question regarding the time that the resident liked to wake up was not answered and left blank. An interview with the DOC on an identified date in January 2016, confirmed that the assessment was not completed in relation to the resident's preferred time to wake and that their plan of care was not based on an interdisciplinary assessment with respect to the residents sleep patterns and preferences. (214) [s. 26. (3) 21.]

3. The licensee failed to ensure that the registered dietitian who is a member of the staff of the home assesses the resident's hydration status, and any risks related to hydration.

A) Resident #082 was noted to be at high nutritional risk. A review of the fluid intake flow-sheets from identified dates in November 2015 until date in January 2016, indicated that the resident had not met their calculated fluid requirements on any dates during this time period. Documentation in the progress notes indicated that the resident was seen by the RD where it was noted that the resident had not met their calculated fluid requirements. Interview with the RD on an identified date in January 2016, confirmed that the resident’s hydration status was not assessed to include interventions to meet the resident’s hydration needs.

B) Resident #030 was noted to be at high nutritional risks. A review of the fluid intake flow-sheets from identified dates in October 2015 until identified dates in December 2015, indicated that the resident had only met their calculated fluid requirements on one date during this time period. The resident was seen by the RD on an identified date in November 2015. Review of the resident progress notes on this date written by the RD indicated that the resident continued to not drink well. Subsequent progress notes on identified dates November 2015, indicated that the resident was drinking poorly and on an identified date in November 2015, the resident was noted not be drinking well. The RD had seen the resident on an identified date in November and December 2015, with no mention of hydration status. On an identified date in December 2015, the monthly progress notes completed by the home which was a summary of the resident's care, under "Food/fluid: are hydration goals met as per care plan?" did not indicate that the resident was not meeting their hydration goals. Interview with the RD on an identified date in January 2016, confirmed that the resident's hydration status was not assessed to include interventions to meet the resident's hydration needs.

C) Resident #018 was noted to be at high nutritional risk. A review of the fluid intake flow-sheets from identified dates in November 2015 until identified dates in January 2016, indicated that the resident had only met their calculated fluid requirements on two dates during this time period. Documentation in the progress notes indicated that the resident was seen by the RD on an identified date in December 2015, where it was noted that the resident had not met their calculated fluid requirements. Interview with the RD on an identified date in January 2016, confirmed that the resident's hydration status was not assessed to include interventions to meet the resident's hydration needs. [s. 26. (4) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:

1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

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:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. 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 failed to ensure that seat belts were applied according to manufacturer's guidelines.

A. On an identified date in October 2015, resident #021 was noted to have slid in their wheelchair while wearing a seat belt restraint. This was identified as a result of Critical incident inspection #028501-15. The DOC confirmed that the seat belt was not applied according to manufacturer's guidelines.
B. On an identified date in December 2015, resident #050 was noted to be wearing a seat belt that was loose fitting and not applied according to manufacturer's guidelines. Interview with registered staff #101 confirmed that the seat belt was loose fitting and more than five inches from the resident's abdomen. The registered staff confirmed that the seat belt was a restraint and the resident could not remove the seat belt.
C. On an identified date in December, 2015, resident #051 was noted to be wearing a seat belt that was loose fitting and not applied according to manufacturer's guidelines. Interview with registered staff #100 confirmed that the seat belt was loose fitting and more than five inches from the resident's abdomen. The registered staff also confirmed that the resident was not to be wearing a seat belt according to their plan of care.
D. On an identified date in January 2016, resident #052 was noted to be wearing a seat belt that was loose fitting and not applied according to manufacturer's guidelines. Interview with DOC confirmed that the seat belt was loose fitting and more than five inches from the resident's abdomen. The DOC also confirmed that the seat belt was a restraint and the resident could not remove the seat belt.
E. On an identified date in January 2016, resident #053 was noted to be wearing a seat belt that was loose fitting and not applied according to manufacturer's guidelines. Interview with DOC confirmed that the seat belt was loose fitting and more than five inches from the resident's abdomen. The DOC also confirmed that the seat belt was a restraint and the resident could not remove the seat belt.
F. On an identified date in January 2016, resident #054 was noted to be wearing a seat belt that was loose fitting and not applied according to manufacturer's guidelines. Interview with DOC confirmed that the seat belt was loose fitting and more than five inches from the resident's abdomen. The DOC also confirmed that the seat belt was a restraint and the resident could not remove the seat belt.
The DOC confirmed that the staff were aware, based on education that they had received, that seat belts used to restrain a resident should be tightened to the distance of approximately two finger widths as per the manufacturer's guidelines. [s. 110. (1) 1.]

2. The licensee failed to ensure that resident #020 was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of

staff as authorized by a member of the registered nursing staff for that purpose.

Observation of resident #020 confirmed that the resident was tilted in their wheelchair during Stage 1 of the RQI. Review of the resident’s clinical record confirmed that the tilt wheelchair was used as a restraint. The plan of care directed to staff to complete the restraint flow every one hour while restrained . Interview with the DOC confirmed that the home was not completing the restraint flow sheet record and the resident was not monitored at least every one hour. [s. 110. (2) 3.]

3. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented, including, all assessments, reassessments and monitoring, including the resident's response, every release of the device and all repositioning.

The “Restraint Flow Sheet” for resident #021 was reviewed for October and December 2015 and January 2016. According to these records, for the month of October there was no restraint documentation recorded from 0700 to 2300 hours on at least 36 of 46 shifts. Including on an identified date in October 2015, when the resident was observed by staff to have slid above their torso while in their wheelchair. For December 2015, there was no restraint documentation recorded from 0700-2300 hours on at least 29 of 62 shifts. From identified date in January 2015, there was no restraint documentation recorded on at seven of 12 shifts. Staff #112 confirmed the restraint documentation was incomplete. This non-compliance was identified as a result of Critical incident inspection #028501-15, which was conducted simultaneously with the RQI. (Inspector #130). [s. 110. (7)]

4. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented, including, all assessments, reassessments and monitoring, including the resident’s response, every release of the device and all repositioning.

The “Restraint Flow Sheet” for resident #021 was reviewed for October and December 2015 and January 2016. According to these records, for the month of October there was no restraint documentation recorded from 0700 to 2300 hours on at least 36 of 46 shifts. Including on an identified date in October 2015, when the resident was observed by staff to have slid above their torso while in their wheelchair. For December 2015, there was no restraint documentation recorded from 0700-2300 hours on at least 29 of 62 shifts. From identified dates in January 2015, there was no restraint documentation recorded on at seven of 12 shifts. Staff #112 confirmed the restraint documentation was incomplete.

This non-compliance was identified as a result of Critical incident inspection #028501-15, which was conducted simultaneously with the RQI. (Inspector #130). [s. 110. (7) 6.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
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 physical devices are applied according to guidelines and residents are monitored at least every one hour while restrained. To ensure residents who are restrained under section 31 of the act are documented on, all assessments, reassessments and monitoring including the residents response and every release of the device, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the policy and procedure for missing laundry complied with.

The home's policy "Identified Issues/Follow up Action, Housekeeping and Laundry Manual" (policy number section: laundry work routines, last revised 03-02-14) indicated that when a resident has any misplaced, unlabelled articles or any other laundry issues the staff member are to complete a Compliments, Complaints and Opportunities form.

During an interview with resident #100 they expressed that they had lost an article of clothing that was labelled. The resident reported to staff member #107 on an identified date in December 2015, that the clothing was missing. Interview with the staff member #107 on an identified date in January 2016, confirmed that the resident did report the missing clothing and confirmed that they did not follow the home's policy and complete the required form for misplaced articles. [s. 8. (1) (b)]

2. The licensee failed to ensure that the policy and procedure for infection control practices was complied with.

The home's policy " Management of a Resident with Extended Spectrum Beta Lactamase (ESBL), Infection Control Manual," (policy number section, Infection Specific Protocol: Antibiotic Resistant Organisms, last revised 08-26-2013) indicated that when a resident is diagnosed with ESBL that supplies such as gloves and gowns will be kept in the residents room.

During an interview with resident #028 the resident expressed that they were concerned about the staff following infection control practices. The resident was on contact precautions and these precautions directed staff to use gowns when skin or clothing will come into contact with the resident or their environment and gloves when providing all direct personal care or cleaning the environment. An observation of the resident's room on two identified dates in January 2016, confirmed that the resident had no gloves or gowns in their room. The DOC confirmed that the home is not following their policy regarding ESBL as it directs that gloves and gowns will be kept in the resident's room. [s. 8. (1) (b)]

3. The licensee failed to ensure that the policy and procedure for dress code was complied with.

The home's policy "Dress Code, Personnel Policy Manual" (policy number-03-01-13, last revised July 2011) indicated that when an employee is working at the home that the employee wear a name identification bar at all times. A concern was brought forth from a family member that staff were not always wearing their name identification bars. Observation on the identified home area confirmed that the two staff members were not wearing their identification bars. The DOC confirmed that the staff were not wearing their name bars as per the dress code policy. [s. 8. (1) (b)]

4. The licensee failed to ensure that the policy and procedure for the complaints and

concerns process was complied with.

The home's policy "Complaints and Concerns Process Administrative Manual" (policy number section: AM-02-01-19, last revised 20-01-14) indicated that when a person has a complaint or concern, the staff member will complete the Complaints and Concern Form.

An interview with registered staff member #123 on an identified date in January 2016, confirmed that the family member of resident#029 expressed a concern/complaint to them in October 2015. The registered staff #123 confirmed that they did not complete the concern, complaint and opportunity for improvement form and did not follow the home's policy for complaints and concerns. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure policies and procedures for missing laundry, infection control, dress code and concerns and complaints are followed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when 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 are none, in accordance with prevailing practices to minimize risk to the resident.

A. During stage 1 of Resident Quality Inspection (RQI) resident #014’s bed system was observed with two bed rails in the upright position. An observation of the resident’s bed system was conducted on an identified date in January 2016. Upon observation, the resident was not in bed and the bed rails were not in the lowered position. An interview with staff #112 confirmed that the resident used two bed rails in the upright position when the resident is in bed for the purpose of assisting staff with bed mobility.

A review of the Activities of Daily Living (ADL) Functional Resident Assessment Protocol (RAP) completed on an identified date in December 2015, indicated that the resident required assistance for bed mobility. A review of the most current assessment titled, “Achieva Physiotherapy Quarterly Re-Assessment,” asked under question C3. - 2b.-if bed rails were used for bed mobility or transfer. This question was not answered and left blank. An interview with the DOC on an identified date in January 2016, indicated that the home did have a bed rail assessment titled, "Restraint and Alternatives Procedure"; however; this assessment was not completed. The DOC confirmed that the bed rails were used to assist the resident with their bed mobility and that no assessment’s had been completed related to the use of the resident’s bed rails. (214)
B. Resident #023 was observed on two occasions, when resting in bed, with a 3/4 bed rail in the raised position and a small rail raised at the top of the right side of the bed. Interview with registered staff #128 and #129 and the resident confirmed that the resident used both rails on a consistent basis. A review of the Bed Entrapment Audit provided by the home, identified that the bed system was a pass, with additional information indicating that there were full bed rails on the bed. A request was made for any additional Bed Entrapment Audits of the identified beds which were reflective of the current bed system in use. On an identified date in January 2016, the home provided a Bed System Measurement Device Test Results Worksheet for the identified bed which noted that the bed was a pass; however, the ED indicated that the bed did not pass with the small wooden rail in place and with the consent of the resident the device was removed. The resident's bed system was not evaluated prior to use when there was a small rail in place as confirmed during interview with the ED as the resident was on isolation when beds were tested previously. (#168) [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 when bed rails were used, the residents were assessed and their bed system was evaluated in accordance with evidence-bases practices and, if there are none, in accordance with prevailing practices to minimize the risk to residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Findings/Faits saillants :

1. The licensee failed to ensure that the home protected residents from abuse by anyone and ensured that residents were not neglected by the licensee or staff.

The records of residents #090, #091, #092, #093 and #094 were reviewed including Critical Incident reports #2931-000019, #2931-000029-15, #2931-000032-15 and #2931-000035. It was noted in the records that: resident #091 physically abused resident #092 on an identified date in June 2015 resulting in physical injury of resident #092; resident #091 attempted to physically abuse resident #093 on an identified date in August 2015; resident #091 physically abused resident #094 on an identified date in August 2015, resulting in physical injury of resident #094 and resident #091 attempted to physically abuse resident #090 on an identified date in September 2015.
The DOC was interviewed and confirmed the accuracy of the information in the above records including; resident #091 physically abused residents #092 and resident #094 resulting in physical injury to both residents. [s. 19.]

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 protects residents from abuse by anyone, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy Zero Tolerance of Abuse and Neglect, AM-02-01-08, dated August 11, 2015, identified actions to be taken by staff in the case of an alleged incident of resident abuse which included to "conduct a head to toe assessment on the alleged victim and document findings if physical abuse is suspected" and the requirement that "a person who has reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director" including "abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident".

A. Resident #070 was provided care on an identified shift in November 2015, which was witnessed by a PSW, who reported it as suspected abuse. The witness immediately reported the incident to the charge nurse on the unit who then observed the status of the resident, as confirmed by interviews with registered staff #100 and PSW #118.
i. A review of the resident's clinical record did not include a head to toe assessment, nor any specific assessment findings of the resident for the identified incident. Interview with

registered staff #100 confirmed that a check of the resident was completed and no concerns were identified; however, that this information was not documented as required in the home's policy.
ii. Registered staff #100 identified that the incident was reported to her immediately by PSW #118 although due to scheduling was not communicated further, until three days later, at which time she reported it to the DOC. Interview with the DOC identified that once the allegation was reported an internal investigation was initiated and confirmed that a report was not submitted to the Director until the fourth day, via the Critical Incident Reporting system.
Staff did not follow the home's policy on Zero Tolerance of Abuse and Neglect.

B. Resident #072 was involved in an incident in April 2015, which required transfer to the hospital for assessment where an injury was confirmed. Following transport to the hospital the home was notified, the same day, that the injuries sustained may had been the result of action towards the resident by a co-resident. The home investigated the allegation of abuse and were not able to verify the concerns expressed. The home did not notify the Director immediately of the allegation of abuse until two days after it was reported to them, which was verified during an interview with the DOC.
C. Resident #028 reported an allegation of abuse from a staff member on an identified date in November 2014, the resident's allegation of abuse took place on an identified date in November 2014. The DOC identified once the allegation was reported to them the internal investigation took place and confirmed that the report was not submitted to the Director immediately via the Critical Incident Reporting system. Staff Did not follow the home's policy on Zero Tolerance of Abuse and Neglect. (506) [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents were complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care plan included, at a minimum, the following: any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks, the type and level of assistance required relating to activities of daily living, customary routines and comfort requirements, drugs and treatments required, known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.

Resident #075 was admitted to the home on an identified date in January 2016. The Point Click Care (PCC) care plan was reviewed six days following admission and was identified to include focus statements and interventions for the following areas only: eating, psychosocial well being, activities and physiotherapy. Interview with the RAI Co-ordinator confirmed that the current care plan was not complete and did not include all of the care needs for the resident. Interview with registered staff #103 confirmed that aside from the plan in PCC and the admission progress note there were no other plans available for the care of the resident. [s. 24. (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 the residents care plans include any risks identified, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was not restrained by the use of a physical device, other than in accordance with section 31 (included in the resident's plan or care) or under the common law duty described in section 36.
A) On an identified date in October 2015, registered staff restrained resident #021 in their wheelchair with a seat belt, which they could not undo, without completing an assessment, obtaining a physician's order and consent from the POA, for a period greater than 12 hours. The need for the restraint was not included in the plan of care and restraint documentation did not include: monitoring of the resident while restrained at least every hour, the time of application, the release of the restraint, repositioning at least every two hours and the effectiveness of the device.

The DOC confirmed the restraint was applied under the common law duty without a physician's order; was not identified on the written plan of care and was not consented to by the POA within 12 hours of the application of the device. (Inspector #130). [s. 31. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the residents restrained by the use of a physical device, other than in accordance with section 31 is included in the plan of care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was dependent on staff for repositioning was repositioned every two hours.

Resident #031, who was dependent on staff for positioning, had a plan of care in place which identified they were to be turned and repositioned and provide skin care every two hours. The resident was monitored on an identified date in January 2016, while they were up in their wheelchair and was not observed to be repositioned or provided skin care during this period of time. The family of the resident, who was in attendance and PSW's #139 and #140 confirmed that the resident was not repositioned nor provided skin care during the identified time period. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents who were dependent on staff for repositioning were repositioned every two hours, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

According to the clinical record, resident #029 made verbal expressions of pain on seven different occasions on identified dates in August 2015, related to the resident having newly identified pain. The DOC confirmed the resident's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose, when the resident's pain was not relieved.[s. 52. (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 when residents are experiencing pain the residents are assessed using a clinically appropriate assessment instrument, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

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

During the lunch meal observation on an identified date in January 2016, on two identified home areas, it was noted that the dessert was served without the clearing of the main course dishes. Several residents were observed still eating their main course with the dessert already served. Interview with PSW #125 and registered staff #126 confirmed that the meals were not served course by course and that this was the usual practice of the home. [s. 73. (1) 8.]

2. The licensee failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A. During the observed meal on an identified date in January 2016, on a home area, resident #080 was observed at the table asleep with the main entrée and dessert in front of them. The resident did not receive encouragement to eat the meal and it was left uneaten. Review of the plan of care for this resident indicated that the resident required assistance in eating and the last MDS assessment indicated that staff needed to encourage the resident to eat at meals. Interview with PSW #125 confirmed that the resident did not receive encouragement or assistance to eat the meal.
B. During the observed meal on two identified dates in January 2016, on a home area, resident #081 was observed at the table asleep with the main entrée and dessert in front of them. No staff were with the resident and the resident was not encouraged to eat the meal. On an identified date in January 2016, the resident did not receive encouragement until a visitor arrived and woke them. Review of the plan of care for this resident indicated that the resident required encouragement and staff were to remain with the resident and provide total feeding. Interview with registered staff #131 confirmed that the resident definitely should have been woken and provided assistance/encouragement to consume the meal.
Residents were not provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

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 residents are served their meals course by course and that the residents receive assistance and encouragement to eat their meals, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team who provided the resident's care was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker (SDM).

Resident #031 was admitted to the home on an identified date in February 2015. A review of the Resident Care Conference - Interdisciplinary Review form, in the clinical record, identified that the initial, six week care conference was not completed until 67 days following admission. Interview with registered staff #103 confirmed, following a review of the clinical record, that the care conference was not completed within six weeks of admission as required. Interview with registered staff #141 confirmed that there was a delay in the completion of the conference due to the number of conferences to be scheduled and conducted during that time. Interview with the SDM confirmed that there was a delay in the completion of the conference and that it was not completed within six weeks of admission. [s. 27. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident has fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #074, who was identified at risk for falls, sustained a fall on an identified date in February 2015, which required transport to hospital. A review of the clinical record did not include a completed post fall assessment, following this incident, including the completion of vital signs. Interview with the DOC identified that the staff were to complete a post fall assessment under the assessment tab in Point Click Care for the fall and following a review of all electronic assessments completed for this resident confirmed that the assessment was not completed as required. [s. 49. (2)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that a response in writing was provided within 10 days of receiving Resident Council advice related to concerns or recommendations.

During an interview with the Resident Council president on an identified date in January 2016, they could not confirm that the home responded to their concerns or recommendations within 10 days. An interview with the Manager of Recreation and Volunteer Services confirmed that responses were completed within 10 days; however they are not posted or shared with the council within 10 days and are only reviewed with the Council at the next Council meeting. [s. 57. (2)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that they sought the advice of the Family Council in the development of the satisfaction survey.

Interview with the Family Council Chair and the Meeting Minutes reviewed, identified that the Council was not consulted for the development of the 2015 satisfaction survey. Discussion with the ED confirmed that the Council was involved in the development of the satisfaction survey in previous years; however, the survey was sent out this year without the consultation of the Council membership. [s. 85. (3)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records

Every licensee of a long-term care home shall ensure that,

(a) a written record is created and maintained for each resident of the home; and

(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that residents' written records were kept up to date at all times.

Resident #056 was involved in an incident of responsive behaviours with resident #103 related to a Critical Incident System (CIS) Report that was submitted to the Director. During a review of the resident's clinical record it was noted that there was no documentation in the resident's clinical file to say that the resident was involved in the incident. The DOC confirmed that this information was not added to the resident's clinical file.[s. 231. (b)]

Issued on this 11th day of February, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LESLEY EDWARDS (506), CAROL POLCZ (156), CATHY FEDIASH (214), GILLIAN TRACEY (130), LISA VINK (168), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2015_240506_0030
Log No. / Registre no:	035240-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 8, 2016
Licensee / Titulaire de permis :	IDLEWYLD MANOR 449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7
LTC Home / Foyer de SLD :	IDLEWYLD MANOR 449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MAUREEN GOODRAM

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

Order / Ordre :

Previously issued as a WN on October 1, 2013.

The licensee shall ensure that when any resident care needs change related to responsive behaviours, safety concerns, lifts and transfers, toileting, the use of physical restraints and changes in medical status, including residents #021, #016, #029 that their residents are reassessed and the plan of care is reviewed and revised.
1. The home is to educate registered staff on the requirement of reviewing and revising all residents plans of care when the residents care needs change.
2. The home is to develop and implement an audit system to ensure that all residents plans of care are reviewed and revised for accuracy.

Grounds / Motifs :

1. 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. The written plan of care for resident #021 indicated that the resident required the use of a certain mechanical device as the resident was unable to weight bear; required a device to assist with ambulation, was incontinent and wore product brought in by family; for psychotropic drug use staff were to observe the

resident's gait and ability to position and turn; and exhibited an identified responsive behaviour. Staff #108 and #112 confirmed the resident no longer required the use of the mechanical lift, but used a different mechanical lift; no longer used the device for ambulation, but required a different device for mobility, because the resident no longer ambulated; and no longer wore the specified product, but required a different product for incontinence and no longer exhibited the specified responsive behaviour. The plan of care was not revised when the resident's care needs changed and when interventions in the plan were no longer necessary. This non-compliance was identified as a result of Critical incident inspection #028501-15, which was conducted simultaneously with the RQI. (Inspector #130).

B. Resident #021 was admitted to the home in August 2015. The day following admission, a progress note indicated the resident was demonstrating a responsive behaviour and for safety staff applied a device. This same day a second progress note indicated that the resident verbalized thoughts that were of safety concern. The following day a progress note indicated the resident set off an alarm and checks were required. Three days after admission a fall intervention was placed next to the resident's bed which was in the lowest position and another safety device implemented as a result of a fall. Two days later staff observed the resident trying to remove the device, therefore the device was removed and placed on another area of their body. Later that month one to one staff was implemented and two days later staff documented that resident was placed in a device for unsteadiness. The following month in October 2015, registered staff documented that the resident was placed in the device with a seat belt and the seat belt had slid to an unsafe position.
The written plan of care was not reviewed and revised when there were changes to the care needs of the resident Interview with the DOC confirmed that the plan of care was not reviewed and revised with the identified changes in the care needs for the resident. (Inspector #130)

C. Resident #016 was newly admitted to the home and was experiencing responsive behaviours. Resident #016 had 12 documented incidents of responsive behaviours or altercations involving co-residents and staff during a 27 day time period in December 2014. The document that the home refers to as the care plan was not revised to include the responsive behaviours or the interventions to manage these behaviours. The DOC confirmed that the care plan was not revised to include the resident's responsive behaviours. (inspector #506)

D. Over a three day time period in August 2015, resident #029 had six documented reports to their clinical record that indicated that the resident was having newly identified pain. During this time the resident was spending more time in bed and requesting pain medications. The physician was not informed of the change in the resident's status until three days later in August, 2015, when the physician ordered the home to complete a x-ray which identified medical concerns. The DOC confirmed that the home did not review and revise the resident's plan of care when the resident's care needs changed. (inspector #506)

E. A review of the clinical record for resident #030 indicated that on an identified date in August 2014, the resident was leaning to the side and that they would monitor the resident. There was no further indication that the resident was monitored, or an assessment of the resident's change in condition completed. The resident's plan of care was not reviewed and revised when the resident's care needs changed. This was confirmed with the DOC on an identified date in January 2016. (inspector #156) [s. 6. (10) (b)] (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 11, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Order / Ordre :

Previously issued as a VPC on September 9, 2014.

The licensee shall ensure that there is a process in place for staff:
1. To calculate the daily fluid intake and hydration status of all residents.
2. To ensure that the dietitian assesses residents hydration status and risks related to dehydration and that interventions are in place for any resident at risk for dehydration including resident's #082 and #018.

Grounds / Motifs :

1. The licensee failed to ensure that the registered dietitian who is a member of the staff of the home assesses the resident's hydration status, and any risks related to hydration.

A) Resident #082 was noted to be at high nutritional risk. A review of the fluid intake flow-sheets from identified dates in November 2015 until date in January 2016, indicated that the resident had not met their calculated fluid requirements on any dates during this time period. Documentation in the progress notes indicated that the resident was seen by the RD where it was noted that the resident had not met their calculated fluid requirements. Interview with the RD on an identified date in January 2016, confirmed that the resident's hydration status was not assessed to include interventions to meet the resident's hydration needs.

B) Resident #030 was noted to be at high nutritional risks. A review of the fluid

intake flow-sheets from identified dates in October 2015 until identified dates in December 2015, indicated that the resident had only met their calculated fluid requirements on one date during this time period. The resident was seen by the RD on an identified date in November 2015. Review of the resident progress notes on this date written by the RD indicated that the resident continued to not drink well. Subsequent progress notes on identified dates November 2015 indicated that the resident was drinking poorly and on an identified date in November 2015, the resident was noted not be drinking well. The RD had seen the resident on an identified date in November and December 2015, with no mention of hydration status. On an identified date in December 2015, the monthly progress notes completed by the home which was a summary of the resident's care, under "Food/fluid: are hydration goals met as per care plan?" did not indicate that the resident was not meeting their hydration goals. Interview with the RD on an identified date in January 2016, confirmed that the resident's hydration status was not assessed to include interventions to meet the resident's hydration needs.

C) Resident #018 was noted to be at high nutritional risk. A review of the fluid intake flow-sheets from identified dates in November 2015 until identified dates in January 2016, indicated that the resident had only met their calculated fluid requirements on two dates during this time period. Documentation in the progress notes indicated that the resident was seen by the RD on an identified date in December 2015, where it was noted that the resident had not met their calculated fluid requirements. Interview with the RD on an identified date in January 2016, confirmed that the resident's hydration status was not assessed to include interventions to meet the resident's hydration needs. [s. 26. (4) (b)] (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 08, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

Previously issued as a WN on September 9, 2014.

The licensee shall ensure all residents who use a physical device;
1. Assessed for the need of the physical device.
2. Education is provided to all staff regarding the application of the physical device according to manufacturer's guidelines.
3. Create an audit to ensure all physical devices are applied in accordance to manufacturer's guidelines.

Grounds / Motifs :

1. The licensee failed to ensure that seat belts were applied according to manufacturer's guidelines.

A. On an identified date in October 2015, resident #021 was noted to have slid in their wheelchair. This was identified as a result of Critical incident inspection #028501-15. The DOC confirmed that the seat belt was a restraint and not applied according to manufacturer's guidelines.
B. On an identified date in December 2015, resident #050 was noted to be wearing a seat belt that was loose fitting and not applied according to manufacturer's guidelines. Interview with registered staff #101 confirmed that the seat belt was loose fitting and more than five inches from the resident's

abdomen. The registered staff confirmed that the seat belt was a restraint and the resident could not remove the seat belt.
C. On an identified date in December, 2015, resident #051 was noted to be wearing a seat belt that was loose fitting and not applied according to manufacturer's guidelines. Interview with registered staff #100 confirmed that the seat belt was loose fitting and more than five inches from the resident's abdomen. The registered staff also confirmed that the resident was not to be wearing a seat belt according to their plan of care.
D. On an identified date January 2016, resident #052 was noted to be wearing a seat belt that was loose fitting and not applied according to manufacturer's guidelines. Interview with DOC confirmed that the seat belt was loose fitting and more than five inches from the resident's abdomen. The DOC also confirmed that the seat belt was a restraint and the resident could not remove the seat belt.
E. On an identified date in January 2016, resident #053 was noted to be wearing a seat belt that was loose fitting and not applied according to manufacturer's guidelines. Interview with DOC confirmed that the seat belt was loose fitting and more than five inches from the resident's abdomen. The DOC also confirmed that the seat belt was a restraint and the resident could not remove the seat belt.
F. On an identified date in January 2016, resident #054 was noted to be wearing a seat belt that was loose fitting and not applied according to manufacturer's guidelines. Interview with DOC confirmed that the seat belt was loose fitting and more than five inches from the resident's abdomen. The DOC also confirmed that the seat belt was a restraint and the resident could not remove the seat belt.
The DOC confirmed that the staff were aware, based on education that they had received, that seat belts used to restrain a resident should be tightened to the distance of approximately two finger widths as per the manufacturer's guidelin[s. 110. (1) 1.] (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 11, 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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, 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 8th day of February, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Lesley Edwards

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