Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
Nov 25, 2015	2015_324567_0006	T-1703-15	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - ELLESMERE
1000 Ellesmere Road SCARBOROUGH ON M1P 5G2

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

SOFIA DASILVA (567), JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), JULIET MANDERSON-GRAY (607)

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): June 30, July 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 2015.

The following intakes were completed concurrently with the Resident Quality Inspection: T-002752-15, T-002235-15, T-001869-15, T-000824-13, T-000825-13 and T-001294-14.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Directors of Care (ADOCs), Director of Dietary Services (DDS), Registered Dietitian (RD), Social Worker, Physiotherapist, Environmental Services Manager (ESM), Resident Assessment Instrument Minimum Data Set(RAI-MDS) Coordinator, Registered Staff, Personal Support Workers(PSWs), Dietary Aides, Cooks, Housekeeping Staff, Residents, Substitute Decision Makers (SDMs), family members, Resident Council assistant, Presidents of Resident and Family Council.

During the course of the inspection, the inspector(s)conducted a tour of the home, made observations of meal service, observed medication administration, observed staff and resident interactions and the provision of care, conducted reviews of health records, complaint and critical incident record logs, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (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; 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 has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of resident #004's clinical record revealed that the resident has a medical order for the use of two side rails when in bed for safety and review of the written plan of care revealed the same.

On July 9, 2015, at 3:12p.m., resident #004 was observed in bed with one side rail in the up position.

Interview with PSW #118 revealed that she was instructed by management not to engage more than one side rail as the ministry inspectors were in the home.

Interview with RPN #132 revealed that the resident is to have two sides rails up when in bed. Interview with ADOC #135 confirmed that staff are expected to follow the plan of care related to side rails. [s. 6. (7)]

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

A review of the progress notes revealed that on an identified date in 2015, while transferring him/herself from the wheelchair to the bed, resident #041 sustained a fall with injury. After the fall, the resident was placed on observation related to the injury. The observations required specific checks at pre-determined intervals.

A review of the health records for resident #041 revealed that the checks were not all completed as outlined in the procedure. A review of the clinical records revealed that during the last check on the resident, the resident could not be roused and was transferred to hospital.

Review of the progress notes revealed that the resident passed away that afternoon in hospital.

Interview with the ADOC #135 confirmed that registered staff did not exercise good judgment in not completing all the checks as per the protocol, as this was part of the resident's plan of care following the fall. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care for resident #026 was not provided as specified in the plan.

Review of Critical Incident Report revealed that on a specified date in January 2015, resident #026 sustained a fall resulting in an injury requiring transfer to hospital for further assessment. During the provision of care to resident #026, while PSW #141 was applying a device, the resident #026 grabbed the PSW's arm, resulting in a fall. The investigation notes revealed PSW #141 was alone while providing care.

Review of the most recent written plan of care indicated that due to behaviours of grabbing and striking out at staff exhibited by resident #026, two staff were to provide care to ensure safety. The written plan of care further stated that if the resident became agitated, staff were to ensure he/she was safe and provide space.

Interview with PSW #141 revealed that he/she was alone and that the side rail was not engaged on the side of the bed he/she was standing on as he/she was applying a device. During this procedure, resident #026 grabbed PSW #141's arm, resulting in the resident slipping and falling to the floor and resulting in an injury.

Review of the home's investigation notes revealed that when PSW #141 attempted to place the device under resident #026, he/she was resistive and more alert than usual,

indicating that care should have been provided by two staff.

Interview with the DOC confirmed that PSW #141 did not provide care as specified in the written plan of care to resident #026. [s. 6. (7)]

4. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care.

Interview with resident #001 revealed that staff do not offer mouth care to him/her.

Interview with PSW #115 revealed that he/she was not aware of what was included in resident #001's written plan of care related to mouth care, as she was newly transferred to the unit three weeks prior and had not had a chance to review the resident's care plan.

Interview with ADOC #117 confirmed that staff should be kept updated and follow the resident's plan of care. [s. 6. (8)]

5. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Record review of resident #004's plan of care revealed that the resident had an alteration in skin integrity in April 2015.

Interview with RPN #109 revealed that the resident no longer had an alternation in skin integrity. Interview with ADOC #117 confirmed that the resident no longer had an alteration in skin integrity and that the written plan of plan was not updated. [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 the plan of care sets out clear directions to staff and others who provide direct care to the resident
-to ensure that 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
-to ensure that the care set out in the plan of care is provided to the resident as specified in the plan
-to ensure that staff and others who provide direct care to a resident kept aware of the contents of the plan of care and
-to ensure that resident reassessed and the plan of care reviewed and revised 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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On July 14, 2015, the inspector observed the electrical room door on 4A propped open with a wooden door stopper. Inside the electrical room the light was not turned on, two ladders were leaning against the wall and the metal electrical panel doors were left wide open.

An interview with PSW #142 and staff #110 revealed and confirmed that technicians were working in the electrical room and that this door should be kept closed and locked when not being supervised. [s. 9. (1) 2.]

2. On June 30, 2015, at 11:22a.m., the inspector observed that the east facility tub room on Harmony Avenue was unlocked and there were no staff present.

Interviews with RPN #101, maintenance assistant #102 and the ESM confirmed that the identified door should be locked when not in use. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to protect resident #031 from abuse by anyone in the home.

Critical Incident Report revealed that on an identified date, resident #025 physically struck resident #031 on an identified part of the body, resulting in an injury.

Record review for resident #025 revealed a pattern of inappropriate behaviours towards other residents and staff since admission on a specified date in 2014.

On specified dates, resident #025 exhibited several instances of responsive behaviours:

As a result of the incidents, the home had found alternative accommodations for resident #025 on a specified date in 2014, and implemented a specified intervention for the resident.

Interview with the DOC revealed and confirmed that on a specified evening a few months later in 2014, resident #025's interventions were not in place and during this time, resident #031 was struck. [s. 19. (1)]

2. The licensee has failed to ensure that resident #003 is protected from abuse by anyone in the home.

An interview with resident #003 revealed that staff #155 was rough with him/her. When asked how, the resident provided both non-specific and specific examples of inappropriate behaviour of the staff towards the resident.

An interview with resident #045 revealed that staff #155 was rough with him/her as well. The resident described the PSW's overall tone and approach as inappropriate and provided specific information to this effect.

The DOC stated she was not aware of these particular incidents, however, did confirm knowledge of the PSW's behaviours. Interview with the DOC confirmed that these actions on the part of the PSW were inappropriate and constituted physical and emotional abuse as well as an abuse of power. [s. 19. (1)]

3. The licensee has failed to ensure that resident #009 was protected from neglect by the licensee or staff in the home.

Interviews conducted for resident #009's family revealed that resident #009 was not provided care required as a result of her condition. PSW #156 was assigned to resident #009 and was made aware of the resident's condition. After a specified amount of time, the resident's condition had not been addressed.

A review of the home's investigation revealed that staff knowingly did not address the resident's condition.

A review of the home's records revealed that the PSW was disciplined for neglect of the resident.

Interview with the ADOC and DOC confirmed that these actions constituted neglect. [s. 19. (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 protect residents #003, #009 and #031 from abuse by anyone in the home, to be implemented voluntarily.

WN #4: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 has failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

Review of resident #001's clinical record revealed that the resident was at risk for altered skin integrity. Review of the resident's clinical record revealed that the resident was hospitalized on specified dates in 2015. Review of the resident assessment records could not locate a skin assessment for the resident upon return from hospital for either of the above hospitalizations.

Interviews with RN #114 and ADOC #117 confirmed that a skin assessment was not completed for the resident upon return from hospital. [s. 50. (2) (a) (ii)]

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

On a specified date in 2015 the inspector observed an alteration in skin integrity to resident #001's right arm. Interviews with PSWs #115 and #116 and RN #114 confirmed that the resident #001 had an alteration in skin integrity to the right arm. In addition, the resident had another area of skin alteration on a specified part of the body.

Review of the resident's assessment record could not locate an assessment for either area of skin alteration.

Interviews with RN#114 and ADOC #117 confirmed that a skin assessment was not conducted for the resident's skin conditions from the time they were identified to the date of the inspection, using a clinically appropriate assessment instrument. [s. 50. (2) (b) (i)]

3. A review of the progress notes revealed that resident #004 had a fall on a specified date in 2015, and sustained an injury.

A review of the assessment record could not locate a skin assessment for the above identified skin alteration.

An interview with RPN #132 and ADOC #117 confirmed that a skin assessment was not done for the above identified skin alteration. [s. 50. (2) (b) (i)]

4. Review of resident #004's written plan of care revealed that the resident had an alteration in skin integrity on a specified date in April, 2015.

A review of the assessment record could not locate a skin assessment for the above-identified alteration. An interview with RPN #132 and ADOC #117 confirmed that an assessment was not done for the above identified alteration. [s. 50. (2) (b) (i)]

5. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

Record review of resident #004's written plan of care revealed that the resident had an alteration in skin integrity in April, 2015.

Record review could not locate that a referral was sent to the dietitian for the above-identified skin alteration.

Interview with the dietitian confirmed that she did not receive a referral for the above-identified altered skin integrity.

Interview with RPN #132 and ADOC #117 confirmed that resident #004 was not assessed by the registered dietitian. [s. 50. (2) (b) (iii)]

6. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of resident #001's clinical records indicated that the resident was identified as having an alteration in skin integrity. A review of the treatments ordered revealed that treatment was ordered every three days and as needed, and that weekly skin assessments were to be conducted using the home's weekly skin assessment tool.

Record review revealed that weekly skin assessments were not conducted for specified weeks in April and May 2015.

Interviews with registered staff #114 and ADOC #117 confirmed that weekly wound assessments had not been conducted for the resident for the above-identified weeks. [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 a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, upon any return from hospital
-to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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
-to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that monthly weights are completed for resident # #002.

Interview with registered staff #110 revealed that when a monthly weight is not obtained the registered staff are to document the reason in the resident's progress notes or in the weights tab of point click care (PCC).

Record review of resident #002's weights revealed that monthly weights for January, March and April 2015, were not completed.

Registered staff #110 and the DOC confirmed that monthly weights for resident #002 were not obtained for January, March and April 2015. [s. 68. (2) (e) (i)]

2. The licensee has failed to ensure that heights are taken annually.

Review of resident clinical records revealed several identified dates for several residents where heights were not measured annually.

Interview with the DOC confirmed that annual heights are to be taken on every resident. [s. 68. (2) (e) (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 that heights are taken annually, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that the drug record book includes the date the drug is received in the home and the signature of the person acknowledging receipt of the drug on behalf of the home.

Review of drug record books for home areas 1A and 3A revealed the following drugs ordered by the home were not signed in as received:
-Latanoprost 0.005 percent
-Liposic Ophthalmic drops
-Alvesco 200 milligrams
-Spiriva with inhaler
-Risperidone oral solution
-Duolobe eight percent over twenty percent (8/20%), Liposic ophthalmic gel, Travatam 0.009 percent and Genteal ophthalmic gel 0.3 percent
-Kayexalate one millimole per gram
-Lactulose
-Trazadone 50 milligrams
-Valproic acid

Interviews with registered staff #108, #153 and the DOC revealed that when drugs are delivered, the evening registered staff are required to sign the drug record book to indicate the drugs were received by the home. [s. 133.]

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 drug record book includes the date the drug is received in the home and the signature of the person acknowledging receipt of the drug on behalf of the home, to be implemented voluntarily.

WN #7: 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:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

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:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff who provide direct care to residents are provided training in falls prevention and management on either an annual basis or based on the staff member's assessed training needs.

A review of the home's training records for falls prevention and management revealed that 16 percent of direct care staff did not complete training in falls prevention and management in 2014. This was confirmed with ADOC #117. [s. 221. (1) 1.]

2. The licensee has failed to ensure that staff who provide direct care to residents are provided training in continence care and bowel management on either an annual basis or based on the staff member's assessed training needs.

A review of the home's training records and an interview with ADOC #117 identified that 16 percent of the staff did not receive training on continence care and bowel management in 2014. [s. 221. (1) 3.]

3. The licensee has failed to ensure that all staff who provide direct care to residents are provided training in abuse recognition and prevention annually.

A review of the home's training records for abuse recognition and prevention revealed that 16 percent of all staff who provide direct care to residents did not complete training in abuse recognition and prevention in 2014. This was confirmed with ADOC #117. [s. 221. (2)]

4. The licensee has failed to ensure that staff who provide direct care to residents are provided training in skin and wound care on either an annual basis or based on the staff member's assessed training needs.

A review of the home's training records and an interview with ADOC #117 confirmed that 16 percent of the staff did not receive training on skin and wound in 2014. The home confirmed that the percentage of staff not trained for all the above-mentioned areas was the same. [s. 221. (2) 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 staff who provide direct care to residents are provided training in -falls prevention and management
-continence care and bowel management
-abuse recognition and prevention
-skin and wound care
on either an annual basis or based on the staff member's assessed training needs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Interviews with residents revealed that during meal service when PSW #155 was present, the PSW would play loud music on a radio that was located close to the dining

tables. On July 8 and 13, 2015, during the lunch meal service in the second floor dining room, the inspector noted that loud and inappropriate music was being played while residents were eating lunch.

Interview with PSW #155 and registered staff #158 revealed that they did not feel the music was loud or inappropriate and that the music was enjoyable for residents and staff. PSW #155 stated that he/she knew that residents enjoyed the music because they danced. The inspector did not observe any residents dancing. PSW #155 also stated that the only resident that would have complained was a specific resident. The inspector interviewed ADOC #117 outside the dining room, where the ADOC revealed that many of the residents were cognitively impaired and that maybe the music was more for the staff. When the inspector asked if the music was meant for the residents or staff, the ADOC replied, it's supposed to be for the residents. The inspector asked the ADOC to step into the dining room near the radio, where residents were dining and to comment on the volume and type of music. The ADOC confirmed that the music was loud and the music was not the type of music that generation would usually listen to. Also, the ADOC confirmed that it wasn't conducive to pleasurable dining, as per the home's policy.

Review of the home's policy titled, Pleasurable Dining, no. VII-1-10.40, revised January 2015, stated that all residents will have a pleasurable dining experience that promotes individual nutritional care needs. The policy also stated that registered staff will oversee and monitor all aspects of Pleasurable Dining, including but not limited to: promotion of a relaxed and quiet dining atmosphere.

Following these incidents, an interview with the DOC confirmed that the home was in the process of disseminating a survey to determine the type of music, if any, the residents wished to listen to during the meal service. [s. 3. (1) 1.]

2. Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

Observations made in the home between July 9 and July 15, 2015, revealed that the following staff were not wearing any form of identification: #125, 152, 159, 117, 112, 110, 111, 121, 123, 122, 135, 157.

Interview with ADOC #117 confirmed that the home was directed to collect staff name tags as a result of the corporate name change from Leisureworld to Sienna Living. The

interview also revealed that an interim system for identification of staff was not put in place to make clear to residents who was providing care to them. [s. 3. (1) 7.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On July 8 and 10, 2015, at 9:52a.m., and 3:34p.m., dirty linen carts and a clean utility cart were observed obstructing the hallway on Dove Lane. During the observation on July 10, 2015, resident #031 was unable to pass through the obstructed hallway.

Interviews with PSW #140, RN#139 and ADOC #135 confirmed that the resident could not access the hand rail on either side of the hallway, which is a safety concern. [s. 5.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee shall ensure that the home, furnishings and equipment are kept clean and sanitary and are maintained in a safe condition and in a good state of repair.

On June 30, 2015, at 11:22a.m., the inspector observed multiple chairs in the dining rooms on the main and second floor soiled with food debris.

Interview with dietary aide #100 and the ESM confirmed that the chairs were soiled and needed cleaning. [s. 15. (2)]

2. On June 30, 2015, at 11:22a.m., the inspector observed the drapes in the dining rooms on the main and second floor grossly soiled with food debris.

Interview with housekeeping supervisor #103 confirmed that the drapes were soiled and needed cleaning. Interview with the ESM confirmed that the drapes were soiled and the ESM informed the inspector that the drapes had been removed for cleaning. [s. 15. (2)]

3. On June 30, 2015, at 11:22a.m., July 08 at 10:02a.m. and July 09 at 9:40a.m., the inspector observed a lounge chair across from room #231 soiled with food debris.

Interview with PSW #118 confirmed that the chair was soiled and needed cleaning. Interview with the ESM confirmed that chair was soiled and the ESM informed the inspector that it had been removed from the unit for cleaning. [s. 15. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistance Service Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living may be included in a resident's plan of care only if all of the following are satisfied: 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.

Record review and interviews with PSW #118 and RPN #132 revealed that resident #004 used a specific device as a PASD. Review of the resident clinical records could not locate an approval for the use of the above identified PASD.

Interview with RPN #132 and ADOC #135 confirmed that there was no approval in place for the resident related to the above identified PASD. [s. 33. (4) 3.]

2. The licensee has failed to ensure that the use of a Personal Assistance Service Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living may be included in a resident's plan of care only if all of the following are satisfied: 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.

Record review and interviews with PSW #118 and RPN #132 revealed that resident #004 used a specific device as a PASD. Review of the resident clinical records could not locate a consent for the use of the above identified PASD.

Interview with RPN #132 and ADOC #135 confirmed that there is no consent in place for the resident related to the above identified PASD. [s. 33. (4) 4.]

WN #12: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

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

Review of the MDS data for resident #011 indicated that the resident experienced a change in continence status on a specified date in 2015, from being frequently incontinent to incontinent.

A review of the resident's assessment record could not locate a bowel and bladder assessment using a clinically appropriate tool when the resident's badder elimination status changed.

Review of the home's policy, titled Continence Management Program, Bladder and Bowel, policy #V3-239, revised September 2013, revealed that registered staff will reassess continence status of the resident annually and with any change in resident condition that affects continence.

Interviews with RN #110 and ADOC #117 confirmed that resident #011 should have had an assessment, as the resident experienced a significant change related to incontinence status. [s. 51. (2) (a)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

A review of the family council minutes revealed that the following concerns were not responded to within 10 days:
-residents feel that holiday based programs should occur on the actual holiday. For example, Valentine's Day should be held on Valentine's day. This was received by the department head on April 8th and a response was provided to family council on May 6, 2015
-families are concerned that creams are being thrown out even though it hasn't expired (when doctor's discontinue medications). This was received by the department head on February 6, 2015 and a response was provided to family council on February 26, 2015.
-family council noted that during the cold period in January 2015, families were not kept informed of what was happening in regards to repairs, length of time to fix and residents were not always dressed, for example, some residents were wearing T-shirts. This was received by the department head on February 6, 2015 and a response was provided to family council on March 2, 2015.

Interview with the family council assistant confirmed that the above mentioned concerns were not responded to within 10 days. [s. 60. (2)]

WN #14: 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 has failed to ensure that they seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

An interview with the Family Council President and the Family Council assistant revealed that the home does not seek the input of the council in the development of the satisfaction survey. The survey is developed by the organization's head office and the Family council is asked to provide feedback, but there is no real opportunity to participate in the development of the survey questions. [s. 85. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when required to inform the Director of an incident under subsection (1), (3) or (3.1), a report in writing to the Director sets out the following with respect to the incident: 3. Actions taken in response to the incident including, v. the outcome or current status of the individual or individuals who were involved in the incident.

A review of Critical Incident Record (CIR)indicated that on a specified date in 2015, resident #026 sustained an injury. The resident was transferred to the hospital and the CIR noted that the resident was transferred back to the long- term care home after a specified amount of time.

Record review of resident #026's health record revealed that on a specified date after the injury, resident #026's spouse made a change to the resident's care plan relating to the resident's prognosis. On a later specified date, resident #026 died at the long-term care home.

Review of the home's investigation notes did not reveal an updated CIR to the Director. Interview with the DOC confirmed that the CIR was not amended to indicate the outcome or current status of resident #026, following the resident's change in status or following the resident's death. [s. 107. (4) 3. v.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that drugs are stored in an area or a medication cart that is secure and locked, and that complies with manufacturer's instructions for the storage of the drugs.

On July 2, 2015, at 1:02p.m., the inspector observed medicated cream on the table in resident #001's room.

Interviews with RN #110 and PSW #152 revealed that the medicated cream should not have been left on the resident's table.

Interview with RN #149 and ADOC #122 confirmed that the medicated creams should not be stored in the resident's room. [s. 129. (1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

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

On July 8, 2015, the inspector observed the 2A medication room door propped open with a wooden door stopper. Inside the medication room was an unlocked treatment cart with a blue basket containing various treatment creams prescribed for several residents. The medication room also housed the medication fridge, which was accessible as it was not equipped with a lock.

Interview with registered staff #120 revealed and confirmed that he/she had forgotten to close and lock the medication room. [s. 130. 1.]

2. On July 13, 2015, from 12:05 to 12:07p.m., the medication cart outside of the dining room on the second floor was unlocked and unsupervised.

Interview with registered staff #158 confirmed that she had just stepped into the dining room for a minute but that she should have locked it when she stepped away. [s. 130. 2. i.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff participate in the implementation of the infection prevention and control program.

On July 8, 2015, observations revealed that registered staff #108 administered medications to three residents without performing hand hygiene in between each resident medication administration.

Interview with registered staff #108 confirmed that he/she did not clean his/her hands before administering medication as was expected by the home.

Interview with the DOC confirmed that it is expected that staff perform hand hygiene before administering medication to each resident. [s. 229. (4)]

Issued on this 1st day of December, 2015

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

Original report signed by the inspector.