Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 29, 2017	2017_572627_0014	016101-17	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Waters Edge Care Community
401 WILLIAM STREET NORTH BAY ON P1A 1X5

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

SYLVIE BYRNES (627), CHAD CAMPS (609), JULIE KUORIKOSKI (621), LOVIRIZA CALUZA (687)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 14-18, and August 21-25, 2017.

The following additional intakes that were submitted to the Director were inspected during this Resident Quality Inspection:

- Three Critical Incidents (CIs) related to resident to resident abuse,
- One CI related to a fall which caused a significant change,
- One CI related to medication or missing narcotic,
- One CI related to improper wound care,
- One Complaint (CO) related to Responsive Behaviours not addressed, and
- One CO related to care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Maintenance Manager, Nurse Practitioner (NP), Resident Relation's Coordinator, Director of Resident Programs, Pharmacy Provider, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Housekeeping Aides, family members, and residents.

The Inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **6 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 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,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who were unable to toilet

independently some or all of the time received assistance from staff to manage and maintain continence.

A)
On August 15, 2017, Inspector #627 observed resident #007 in their room, visiting with a family member. The family member stated that the resident needed continence care, however no one had come in the room since the resident had returned from the meal service. The Inspector noted that the room had a foul odour, the pique pad on the bed and the resident's right upper pant leg were soiled. Resident #007's family member further stated that when they came to visit with resident #007, they often found them in a soiled brief.

On August 17, 2017, the Inspector entered resident #007's room and noted a foul odour. The right hip area of the resident's pant leg was soiled. A Personal Support Worker (PSW) was observed entering the room and assisted the resident to the dining room for a meal service. The Inspector observed the resident sitting in the dining room and a foul odour was noted.

On August 18, 2017, the Inspector observed resident #007 in the dining room for a meal service. After the meal service, the resident took part in an activity conducted in the dining room. When the activity was completed, the resident was observed sleeping at the dining room table. Approximately one hour and a half later, the resident was observed getting up from their chair. A staff member directed them to sit down as the next meal service was to begin shortly.

Inspector #627 reviewed resident #007's care plan in effect at the time of the inspection and noted their continence care needs including but not limited to directing the resident to the bathroom and or check/change incontinent product upon rising, before and after meals and at night time.

B)
On August 17, 2017, Inspector #627 observed resident #021 being assisted to the lounge after a meal service. Two and a half hours later, the Inspector noted that resident #021 remained in the lounge where they were assisted to, covered with a blanket. The Inspector touched the resident's outer thigh and wheelchair seat and noted that both were soiled. Approximately half an hour later, the Inspector observed a staff member bring the resident to the dining room for the next meal service. The resident was not assessed for their continence needs.

The Inspector reviewed the care plan in effect at the time of inspection for resident #021 and noted their continence needs included but not limited to staff checking and/or changing incontinent product upon rising, before and after meals, and at night time.

C)
On August 17, 2017, Inspector #627 observed resident #032 walking from the dining room, after a meal service and sitting in front of the nursing station area. The Inspector noted a foul odour when the resident walked by. Two hours and forty five minutes later, the Inspector approached the resident who remained sitting in front of the nursing station and noted that there remained a foul odour from the resident. The Inspector encouraged the resident to stand and noted that the back of the resident's pants were soiled. A PSW who observed the Inspector and the resident, took the resident to their room and provided them with continence care.

Inspector #627 reviewed resident #032's care plan in effect at the time of the inspection and noted their continence care needs included but not limited to directing the resident to the toilet upon rising, before and after meals and at night time.

On August 18, 2017, Inspector #627 interviewed PSW #112 who stated that everyone had their briefs changed with morning care, however the rest of the day "did not work out often" in regards to continence care. They confirmed that residents #032, #021 and #007 had not been provided with continence care as they should have been.

On August 21, 2017, Inspector #627 interviewed PSW #114 who stated that residents were to be toileted and provided with continence care according to their care plans. They further stated that residents who were incontinent received brief changes when they were assisted to bed for naps. They further stated that residents should be checked for incontinence in the morning, before and after meals. It was reported to the registered staff and documented if a resident refused toileting assistance or a brief change.

On August 21, 2017, the Inspector interviewed Registered Nurse (RN) #113 who stated that residents were to be toileted and have their briefs checked or changed according to their care plan. RN #113 stated that it was disheartening that the above noted residents had not received continence care as stated in their care plan. They further stated that this was not acceptable and wished that staff had made them aware, so that they could have assisted them, and that this had to be addressed.

On August 21, 2017, the Inspector interviewed the Director of Care (DOC) who stated that it was the home's expectation that all residents received assistance with continence care to ensure they remained comfortable and dry, in order to protect their skin integrity, dignity and decrease behaviours. The DOC acknowledged that resident #007, #021 and #032 had not received assistance from staff for their continence needs.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that corrective action was taken in relation to all medication incidents and adverse drug reactions.

A Critical Incident (CI) report, was submitted to the Director. The CI report indicated that resident #021's medication patch went missing.

On August 22, 2017, during an interview with Inspector #609, the DOC stated that in 2016 there were three medication incidents whereby medication patches went missing. The DOC further indicated that in May 2017, three additional incidents of missing medication patches had occurred and that there was a trend in the home of missing medication patches.

A review of the home's policy titled "Medication Incident Reporting", last reviewed 2017, indicated that reporting of incidents was for the purpose of evaluation in order to focus on process improvement and the reduction of future incidents.

During the same interview with the DOC, they verified that three times a day medication patch checks were implemented over a year ago in response to the missing medication patches and that it had not been effective in decreasing the incidents of missing medication patches in the home. The DOC indicated they had not put any other intervention or corrective action in place since the third incident of a missing medication patch in 2017, and was unsure what interventions could be implemented. They further indicated that they would reach out to other homes to develop and implement corrective actions to decrease the incidents of missing medication patches in the home.

On August 22, 2017, during an interview with Inspector #609, the home's Pharmacy Provider stated that they were not aware of the May 2017 missing medication patch incident and had they been made aware, they would have recommended that the home utilize two registered staff when performing the three times a day medication patch checks as a corrective action instead of one registered staff, as was the home's current practice. [s. 135. (2)] (609)

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. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

During a family interview, a complaint was voiced in regards to shortage of staff, which caused the resident to not receive appropriate care.

On August 21, 2017, between 1820 and 1830 hours, during a tour of a home area, Inspector #609 noted that many residents were in bed with their night clothes on: resident #007, #020, #021, #032, #037, #038, #039, #044, #045, #046, #048, and #049.

On August 22, 2017, at 1820 hours, Inspector #627 completed further observations on the same home area and noted that 12 residents were in bed, in their night clothing: #020, #021, #032, #037, #038, #039, #040, #041, #042, #044, #045 and #046.

Inspector #627 reviewed the care plans in effect at the time of the inspection for the above residents and noted that for residents #007, #020, #021, #032, #037, #038, #039, #040, #041, #042 and #044, a preferred bedtime was specified which was later than the observation of the Inspector. Residents #045, #046 and #049's care plans had not indicated a preferred bed time.

A review of the home's policy titled "Resident's Bill of Rights", last reviewed on January 2015, indicated that "a plan of care was a written document that said what kind of care a resident needed and how that care was to be provided. Your plan of care was unique to you".

On August 21, 2017, Inspector #609 interviewed PSW #119 who stated that in the past, the specific home area was staffed with a certain number of PSWs, however there was one less PSW now. This was challenging as many of the residents had responsive

behaviours. The unit was too small and there was not enough room to manage all the residents. The residents gathered in front of the nursing station and became responsive towards each other. The evening shift now had to put away the laundry which was disturbing to the residents and took away from resident care.

On August 22, 2017, Inspector #627 interviewed PSW #124 who stated that after dinner, around 1800 hours, the residents who required to be transferred with a mechanical lift were provided with night time care and transferred to bed. The care was completed at this time as the unit had a lot of residents with responsive behaviours. Two staff members were required to monitor the ambulatory residents. The residents who required mechanical lifts were also transferred in bed for the night to offload pressure from sitting in a wheelchair.

On August 22, 2017, Inspector #627 interviewed PSW #120 who stated that after dinner, the PSWs transferred the residents who required mechanical lifts to bed and provided them with night time care. The PSW stated that these residents needed to go to bed first as they had big chairs, and there was no place to sit them on the unit. They further stated that there were a lot of responsive behaviours on the unit which were challenging, and there was only so many PSWs to provide care. They further stated that two PSWs were required to transfer a resident with a mechanical lift, one PSW toileted the ambulatory residents and one PSW was required to stay in the lobby to monitor the residents' responsive behaviours. PSW #120 stated they had not followed the residents' bedtime preference as this was not achievable, especially with the added duties such as putting laundry away and providing the nourishment pass. They further stated that they had done the best they could.

On August 23, 2017, the Inspector interviewed the DOC who stated that the home attempted to pay particular attention to the residents' sleep pattern and preference by indicating a range of the preferred bedtimes, and that the care plans were to be current. The DOC stated that it was not acceptable to have residents in bed at approximately 1830 hours, unless this was their preference. They further stated that the home was here for the residents and the care was to be resident focused, and that the care plans were to be followed including the residents' preferred bedtime routines.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.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. (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 there was a written plan of care that sets out clear directions to staff and others who provide direct care to the resident.

Resident #007 was identified as having had a fall in the last 30 days from the past to most recent Minimum Data Set (MDS) assessment.

Inspector #627 reviewed resident #007's electronic records which identified that the resident had sustained a fall with no injury on a specific date. During the same record review, the Inspector noted a physiotherapist follow up assessment, which identified that that resident #007 would have benefitted from a "specific intervention" related to ambulation for safety reason. Resident #007 was a high risk to fall.

The Inspector reviewed the written plan of care for resident #007 which identified under

the focus of mobility that the resident required a certain level of assistance for mobility. Under the focus of high risk for falls, it was identified that resident #007 required supervision only when ambulating.

The Inspector interviewed PSW #118 who stated that resident #007 required no aids for ambulation. They required supervision from staff only.

The Inspector interviewed PSW #112 who stated that resident #007 was at a high risk for falls. They had been deteriorating physically and that they required staff assistance for ambulation.

The Inspector interviewed RN #113 who stated that resident #007 ambulated independently, without aids and needed supervision only during ambulation.

The Inspector interviewed RPN #117 who stated that resident #007 was at a stage where they no longer realized that they could not walk on their own. They had been assessed for additional interventions, however it was determined that this would cause a hazard due to the resident's confusion. The resident required varying levels of assistance when ambulating depending on their physical condition. The RPN confirmed that the written plan of care had not provided clear directions to staff and stated that they would update it. [s. 6. (1) (c)] (627)

2. On August 18, 2017, Inspector #621 observed resident #010 with a specific intervention in place.

During another observation on August 21, 2017, Inspector #621 observed resident #010 with the same intervention in place.

During an interview on August 21, 2017, RPN #116 and PSW #138 reported to Inspector #621 that resident #010 was a risk for falls. RPN #116 and PSW #138 reported that as part of resident #010's plan of care, they utilized a specific intervention. Additionally, PSW #138 and RPN #116 indicated that information pertaining to the resident's care needs with respect to falls risk was found in resident #010's kardex and care plan.

On August 21, 2017, Inspector #621 reviewed resident #010's care plan in effect at the time of inspection. Under the focus of "Risk for Falls", the Inspector was unable to locate any information identifying the specific intervention.

On August 21, 2017, PSW #138 and RPN #116 reviewed resident #010's most current Kardex and care plan with the Inspector and confirmed that the written plan of care had not provided clear directions to staff and others providing direct care to this resident, with respect to use of a the specific intervention.

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

Resident #002 was identified as having had a decrease in continence from admission to the most current MDS assessment.

Inspector #609 reviewed resident #002's admission MDS assessment which indicated that the resident was occasionally incontinent of bowel and bladder. The next MDS assessment indicated that the resident was frequently incontinent, while the most recent MDS assessment indicated that the resident was now incontinent all or most of the time.

A review of resident #002's most recent Bladder and Bowel Continence assessment indicated that the resident's urinary incontinence had worsened to both day and night since the admission assessment. Since admission, the resident's bowel incontinence had worsened to daily.

A review of resident #002's current plan of care outlined how the resident was frequently incontinent of bowel and that staff were to direct the resident to the bathroom. The care outlined for the resident's bladder incontinence was to provide them with a specific type of equipment, and to direct the resident to the bathroom.

On August 24, 2017, during an interview with the Inspector, PSW #126 indicated that resident #002 was totally incontinent of bowel and bladder, that they could not toilet themselves with direction only, required physical assistance and no longer used the specific type of equipment.

On August 24, 2017, during an interview with the Inspector, RPN #130 verified that resident #002 did not use the specific type of equipment and also required physical assistance with toileting.

A review of the home's policy titled "Resident Assessments", indicated that the resident's plan of care was to be revised when there was a change in resident status.

On August 24, 2017, during an interview with the Inspector, the DOC verified that resident #002's plan of care should have been revised with their increased incontinent care needs, previously identified through the MDS and continence assessments. [s. 6. (10) (b)] (609)

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 plans of care resident #007, #010, residents' on isolation precautions and all other residents, set out clear directions to staff and others who provide direct care to the residents. Additionally, ensure that resident #002's and all other residents' written plan of care are reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

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 a secure outside area that precluded exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

On August 15, 2017, Inspector #627 observed that resident #029's patio door (leading to a secure area) was opened and unlocked. The Inspector observed that the patio door had a key lock and a toggle lock. The resident stated to the Inspector that they enjoyed having the door opened as they had a cool breeze. The resident further stated that they locked the door with the toggle lock, however the key lock was never locked.

On August 15, 2017, during a tour of the home, Inspector #609 observed that the patio doors in the dining rooms of two of the home areas (leading to secured areas) had toggle locks which could be unlocked by turning the toggle in the downward position. Signs were noted beside the patio doors instructing to “keep locked when not in use”. The Inspector was able to easily unlock the door latch. At this time the patio door in one of the home areas was opened and unlocked.

As the toggle locks permitted the resident to unlock the door, the locks had not accomplished the restriction of unsupervised access to the secure outside area, as the resident(s) could have accessed the secure area at any time.

August 21, 2017, Inspector #627 interviewed RPN #115 who stated that staff had not locked resident #029’s patio door as they enjoyed the breeze in their room and that the resident locked it themselves, using the toggle lock.

August 21, 2017, during an interview with DOC, they stated that the patio door in resident #029’s room should have been kept locked. The door could have been opened when family or staff were in the room with the resident, however, it should be locked when the resident was without supervision.

On August 22, 2017, Inspector #627 interviewed the Maintenance Manager who stated that the patio doors on the two specified home areas, only had toggle locks. The home was aware that they needed changing as the residents could open the locks. The home was in the process of getting quotes for key locks and door alarms. [s. 9. (1) 1.1.] (627)

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 patio doors in specific home areas, and the patio door in resident #029's room are locked in such a way to restrict unsupervised access to the secure areas outside by residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On August 15, 2017, Inspector #621 observed the seat cushion and foot rest area of resident #003's wheelchair to be soiled with food debris and spill stains.

On August 16, 2017, Inspector #621 observed resident #003's wheelchair with their seat cushion and foot rest area continue to be soiled with food debris and spill stains.

On August 17, 2017, Inspector #621 reviewed the "Chairs Cleaning" schedule for August 2017, on a specific home area, which identified that resident #003's wheelchair was to have been cleaned weekly. It was noted that cleaning of resident #003's wheelchair was initialed by PSW #108 and #109 as being completed on August 15, 2017.

On August 17, 2017, PSW #110 observed resident #003's wheelchair and confirmed to the Inspector that the seat cushion and foot rest were soiled with food spills, stains and food debris.

During an interview with the Inspector, RN #105 reported that PSW staff were responsible for the cleaning of residents' wheelchairs at least once weekly according to the "Chairs Cleaning" schedule located in a designated binder at each nursing unit.

On August 17, 2017, RN #105 reviewed the PSW "Chairs Cleaning" schedule and staff schedules for August 2017, and reported to Inspector #621 that for a specific day during that month, PSWs #108 and #109 had signed off as having completed the cleaning of resident #003's wheelchair two days prior. RN #105 then observed resident #003's wheelchair while the resident was in their chair and confirmed spill stains were present on the resident's foot rest.

During an interview with the Inspector, the DOC reported that it was their expectation that PSW staff cleaned all resident wheelchairs once a week according to the "Chair Cleaning" schedule, and more often if needed. Additionally, the DOC reported that they recognized a gap in their processes, where auditing of the cleaning schedules had not been completed by the home to ensure that scheduled cleaning of resident's ambulation equipment, including wheelchairs was being completed. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home's furnishings and equipment were maintained in a safe condition and in a good state of repair.

During the course of the inspection, disrepair to common areas was identified.

a) On August 17, 2017, Inspector #609 observed five resident bathrooms on each of the home's three floors also known as Piers, for a total of 15 residents' bathrooms. The Inspector observed that 11 of the 15 residents' bathrooms, or 73 per cent had damage and disrepair which included:
-One light burned out;
-Water damaged cupboard;
-No lighting fixture cover;
-Burnt out light and tiles discoloured in room;
-No light fixture cover, scraped and gouged walls in room;
-Scraped and gouged walls in room;

-Gouged walls as well as a broken, sharp edge to the bathroom door in room;
-Discoloured tiles in room;
-Worn tiles in room;
-No lighting fixture cover in room; and
-No lighting fixture cover and water damaged cupboard in room.

Inspector #621 reviewed copies of the Family Councils' meeting minutes. The Inspector found in the minutes for a specific month, a report that council members had concerns regarding cleanliness and building maintenance.

Inspector #609 reviewed of the home's policy titled "Interior Finishes and Surface Protection Program", which indicated that an audit was to be conducted throughout the home to determine painting and surface protection deficiencies and that an action plan was to be developed to maintain an attractive interior finish. Items in the action plan were to be completed in a timely fashion.
Inspector #609 reviewed the quarterly resident room audit for a specific room, and noted that it had not identified the broken bathroom door. Another room's audit had not identified the missing light fixture cover while the home failed to produce any documentation of an audit for another room.

Two of the rooms' indicated that the bathrooms had no light fixture cover. They remained unrepaired four months after they were identified by the home.
During an interview with the Inspector, the Maintenance Manager verified that keeping up with the maintenance of the home had been a struggle.

b) On August 18, 2017, Inspector #609 observed every resident room door and door frame and found:
-Of the 14 resident room doors and frames on a certain home area, seven or 50 per cent had scraped and chipped paint;
-Of the 26 resident room doors and frames on another home area, 24 or 92 per cent had scraped and chipped paint;
-Of the 26 resident room doors and frames on another home area, 23 or 88 per cent had scraped and chipped paint; and
-The plastic trim to two rooms' doorway as well as the trim to the right side of a nursing station was broken and sharp to the touch.
During an interview with the Inspector, the Administrator verified the door and door frame observations. They indicated that it was a challenge to maintain the surface on resident room doors and frames because of high traffic from residents, staff and visitors. The

Administrator further verified that broken sharp pieces of plastic trim identified by the inspector posed a safety risk to residents. [s. 15. (2) (c)]

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' wheelchairs are kept clean and sanitary, and to ensure that the home's furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #7: 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 has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinical appropriate assessment instrument that was specifically designed for falls.

Resident #010 was identified as having had a fall from the past to most recent MDS assessment.

On August 17, 2017, Inspector #621 reviewed resident #010's health care record, including a progress note which indicated that the resident had fallen. On further review of the health care record, the Inspector was unable to locate a post-fall assessment, following resident #010's fall.

On August 21, 2017, Inspector #621 reviewed the home's policy titled "Falls Prevention – VII-G-30.00", which identified that when a fall occurred, registered staff were to complete an electronic post fall assessment .

On August 21, 2017, during an interview with the Inspector, RPN #116 identified that a post fall assessment was to be completed by registered staff after every fall, and that this was completed and available on the resident's electronic health record. RPN #116 reviewed resident #010's electronic health record and confirmed to the Inspector that for the fall which occurred on a specific date, a post fall assessment had not been completed. [s. 49. (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 when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinical appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

A CI report was submitted to the Director alleging resident to resident abuse. The CI report indicated that resident #006 struck resident #030 repeatedly.

On August 17, 2017, Inspector #627 observed resident #006 in resident #031's room. Later that morning, both residents left the room to go to the dining room, almost one hour and a half later. At a later time that same day, resident#006 was observed in resident #031's room. They remained there at shift change, almost two and a half hours later.

On August 18, 2017, Inspector #627 observed resident #006 in resident #031's room. They remained when the Inspector left the unit, more than one hour and a half later. After a meal service, resident #006 was observed walking with resident #031 to their room.

Inspector #627 reviewed the care plan in effect at the time of the inspection and noted an intervention under the focus of responsive behavior that "resident #006 was not to go in resident #031's room".

Inspector #627 reviewed a progress note dictated by the attending physician which stated the resident #006 demonstrated certain responsive behaviours towards resident

#031. Resident #006 was increasingly resistive to being redirected out from the room when personal care was given to other co-residents.

The Inspector interviewed PSW #112 who stated that resident #006 spent a lot of time in resident #031's room and felt that the care plan had not been updated. They stated that they had not demonstrated any physical responsive behaviours recently, and that resident #006 was cooperative with them when they asked them to leave the room, however they were not as cooperative with all the PSWs. They further stated that they felt it may be an issue on the night shift.

Inspector #627 interviewed RN #113 who stated that resident #006 became "annoyed" by other residents if they got in their way and at times would strike out at them. After the incident with resident #030, interventions were put in place to prevent resident #006 from entering resident #031's room. Resident #006 and #031 were to spend time together in the lounge and not in the resident's room. RN #113 confirmed that resident #006 was not to be in resident #031's room.

Inspector #627 interviewed the DOC who confirmed that the resident was not to enter resident #031's room. They stated that resident #006 was unpredictable and interventions had been put in place to decrease the risk of altercations between resident #006 and the other residents in resident #031's room. They were to meet in the lounge to ensure the safety of the other vulnerable residents in the room, as well as resident #031. The DOC confirmed that the interventions in place were not being implemented. [s. 54. (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 interventions to minimize the risk of altercations and potentially harmful interactions between resident #006 and other residents are implemented, to be implemented voluntarily.

WN #9: 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 staff participated in the implementation of the infection prevention and control program.

During a tour of the home, Inspector #609 observed six rooms with contact isolation precautions posted. Additionally, Inspector #609 observed that two of the rooms had a number of residents residing in each room. On further review of the isolation precautions posted at the entrance doors of these rooms, it was unclear which resident (s) were on the isolation precautions.

On August 16, 2017, Inspector #621 observed isolation precaution signage posted at the entrance of a specific resident's room where a number of resident resided. The isolation precaution signage posted at the door indicated that droplet and contact precautions were required. The signage also listed both acute and non-acute care precautions, which had their different personal protective equipment requirements. Specifically, the "Acute Care" precautions identified that: a) gloves were to be worn on room entry ; b) gowns were to be worn for direct care or when in contact with items in a patient's environment; and c) a mask and eye protection to be worn within two meters of the resident, whereas the "Non-Acute Care" precautions identified that a) a gown and gloves were to be worn when providing direct care or when in contact with items in the resident's environment; and b) to wear a mask and eye protection within two meters of the resident.

The Inspector also observed personal protective equipment (PPE) on the door of another specific room which included masks, "Accel" sanitation wipes, disposable gloves, gowns, and a garbage bag for disposal of the PPE. The Inspector did not observe the availability of eye protection PPE as indicated to be required on the isolation precaution signage. Additionally, the Inspector observed that there were no isolation precaution identifiers at the bedside of any of the residents in the room .

On August 22, 2017, Inspector #621 observed resident #027's family member enter their room without wearing gloves or a gown, and make contact with items in resident #027's room area.

During an interview with the Inspector, Housekeeping Aide #107 and PSW #108 reported that the only resident on isolation precautions was resident #026, related to specific type of bacterial infection. PSW #108 further identified that staff wore gloves and gowns when providing direct care to the resident, and otherwise had not worn PPE when entering the room.

During an interview with the Inspector, PSW #109 reported that resident #026 and #027 were both on contact isolation precautions related to infection. PSW #109 reported to the Inspector that staff and visitors were to follow procedures as posted on the isolation signage related to PPE requirements. When the Inspector inquired how visitors would know which isolation precautions to follow based on the signage posted at the room, PSW #109 reported that visitors would be unable to determine what precautions were in effect or what to do before entering the room if relying only on the information posted. Additionally, PSW #109 reported that families of both resident #026 and #027 visited often and were not observed to gown or glove before entering these resident's areas or when making contact with items in these resident's environments.

During subsequent interviews with the Inspector, RNs #105 and #106 reported that resident #026 and #027 had an acquired infection and required staff and visitors to follow contact precautions as part of their plans of care, which included wearing gloves and gowns to provide direct care or when making contact with items in these residents' environments. When the Inspector inquired if these residents were also on droplet precautions, RN#105 indicated that resident #026 had recently acquired another infection, but that had since been resolved and was no longer on droplet precautions. When RNs #105 and #106 were asked how visitors of resident's entering the room would know which residents required of them to wear PPE, they reported to the Inspector that family were provided education when isolation precautions were put into effect, and read the posted isolation precaution signage. RNs #105 and #106 reviewed the isolation signage posted at the entrance of the room with the Inspector and confirmed that the droplet precautions that were posted were no longer in effect, that signage to inform visitors to get instructions from staff before entering was missing, and that details pertaining to which PPE was required for contact isolation was not clear.

Inspector #621 reviewed resident #026 and #027's care plans in effect at the time of the inspection, which identified each resident was on contact isolation precautions related to an infection.

During an interview with the Inspector, family members of resident #026 and #027 identified that they had never received education from the home regarding what visitors were required to do if entering into a resident room where isolation precautions were posted.

During an interview with the Inspector, the DOC reported that it was their expectations that isolation precaution signage was not only posted at the room entrance, but at the bedside of those residents who required additional infection control precautions. Additionally, the DOC identified that it was their expectation that staff were performing ongoing surveillance of resident areas and provided education and re-education to visitors who were found not to be following the appropriate isolation precautions when entering resident rooms who were on isolation precautions. During observations by Inspector #621 and the DOC, the DOC confirmed to Inspector #621 that family of resident #027 had entered the room without wearing a gown or gloves, and was in contact with items in resident #027's room area. Furthermore, the DOC confirmed that contact precautions posted at the entrance of the room provided unclear direction as to whether acute or non-acute care isolation precautions were in effect, and that no isolation identifiers were posted at the bedside of resident #026 or #027 to differentiate which residents in this room required the additional isolation precautions. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program by ensuring isolation precaution signage is posted clearly identifying the type of precaution required and that visitors were educated on the requirements and the need to follow the infection prevention and control program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a written complaint concerning the care of a resident is received, it shall be immediately forward it to the Director.

A complaint was submitted to the Director regarding care concerns for resident #036. The complaint alleged neglect towards resident #036 in regards to different aspects of their care.

During an interview with Inspector #627, the resident's family member stated that they had been in communication with the home in regards to the many care concerns they had. They acknowledged that the home had resolved many of the concerns, however there remained concerns regarding the staffing levels in the home and the amount of time residents waited to receive care. They further stated that they had brought their concerns forward to the Administrator, verbally then via email. The resident's family member was unable to recall when they had first verbalized their concern to the Administrator.

The Inspector reviewed email correspondence provided to the Inspector by the Administrator which identified correspondence between the home and resident #036's family member for a period of approximately one month. The Inspector also noted an email from the Vice President of Sienna Living to the Administrator, stating "we will need to consider this as a written complaint".

The Inspector interviewed the Administrator who stated that the home had addressed the concerns of resident's #036's family member. They had also submitted a CI report regarding the written complaint to the Director on a specific date, two days later than the previous correspondence between the home and the complainant. They stated that they had not reported the complaints at an earlier date as they were unsure if an email was considered a written complaint and waited from direction from Sienna Living's Vice President. [s. 22. (1)]

WN #11: 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 if the Family Council advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee responded to the Family Council in writing, within 10 days of receiving the advice.

During an interview with Inspector #621, the Family Council President reported that over the past year the home's management were made aware of concerns and recommendations that were expressed at Family Council, but that Family Council had not received written responses from the home's management related to their concerns.

Inspector #621 reviewed copies of the Family Councils' meeting minutes. The Inspector found in a certain month's minutes, a report that council members had concerns regarding cleanliness and building maintenance.

During an interview with the Inspector, the Administrator identified that they were aware of concerns documented for the certain month's Family Council meeting minutes related to cleanliness of the home and building maintenance, but that they had not provided a written response within 10 days as per legislative requirements. [s. 60. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and the Registered Dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Inspector #609 reviewed of the home's policy titled "Program Evaluations", last revised January 2015, which indicated that the Medication Management System was to be evaluated annually.

Inspector #609 reviewed the home's policy titled "Medication Incident Reporting", dated 2017, which indicated that the home's interdisciplinary team which included the Administrator, DOC, Medical Director and Pharmacist were to be involved in the review of the medication management system.

A review of the home's Quality Management annual evaluation of the medication management system for the 2016 year dated February 27, 2017, found registered staff only participated in the evaluation.

During an interview with the Inspector, the DOC stated that a review of the Regulation was conducted. The DOC verified that the Medical Director, the Administrator, the Pharmacy Provider and the Registered Dietitian were not involved in the 2016 annual evaluation of the medication management system. [s. 116. (1)]

Issued on this 19th day of October, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE BYRNES (627), CHAD CAMPS (609), JULIE KUORIKOSKI (621), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2017_572627_0014
Log No. / No de registre :	016101-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 29, 2017
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	Waters Edge Care Community 401 WILLIAM STREET, NORTH BAY, ON, P1A-1X5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Hoss Notarkesh

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, 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) (b)

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

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

(iv) promote continued independence wherever possible, and

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan of a process to ensure that residents residing on a specific home area, who are unable to complete a certain ADL independently some or all of the time receive assistance from staff to manage and maintain their ADLs.

This plan shall be submitted in writing to Sylvie Byrnes, Long Term Care Homes Nursing Inspector, Long-Term Care Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or faxed to the Inspector's attention, at (705) 564-3133, or email SudburySAO.moh@ontario.ca. This plan must be submitted by October 13, 2017.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents who were unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

A)
On August 15, 2017, Inspector #627 observed resident #007 in their room, visiting with a family member. The family member stated that the resident needed continence care, however no one had come in the room since the resident had returned from a meal service. The Inspector noted that the room had a foul odour, the pique pad on the bed and the resident's right upper pant leg were soiled. Resident #007's family member further stated that when they came to visit with resident #007, they often found them in a soiled brief.

On August 17, 2017, the Inspector entered resident #007's room and noted a foul odour. The right hip area of the resident's pant leg was soiled. A Personal Support Worker (PSW) was observed entering the room and assisted the resident to the dining room for a meal service. The Inspector observed the resident sitting in the dining room and a foul odour was noted.

On August 18, 2017, the Inspector observed resident #007 in the dining room for a meal service. After the meal service, the resident took part in an activity conducted in the dining room. When the activity was completed, the resident was observed sleeping at the dining room table. Approximately one hour and a half later, the resident was observed getting up from their chair. A staff member directed them to sit down as the next meal service was to begin shortly.

Inspector #627 reviewed resident #007's care plan in effect at the time of the

inspection and noted their continence care needs including but not limited to directing the resident to the bathroom and or check/change incontinent product upon rising, before and after meals and at night time.

B)
On August 17, 2017, Inspector #627 observed resident #021 being assisted to the lounge after a meal service. Two and a half hours later, the Inspector noted that resident #021 remained in the lounge where they were assisted to, covered with a blanket. The Inspector touched the resident's outer thigh and wheelchair seat and noted that both were soiled. Approximately half an hour later, the Inspector observed a staff member bring the resident to the dining room for the next meal service. The resident was not assessed for their continence needs.

The Inspector reviewed the care plan in effect at the time of inspection for resident #021 and noted their continence care needs including but not limited to staff checking and/or changing incontinent product upon rising, before and after meals, and at night time.

C)
On August 17, 2017, Inspector #627 observed resident #032 walking from the dining room, after a meal service and sitting in front of the nursing station area. The Inspector noted a foul odour when the resident walked by. Two hours and forty five minutes later, the Inspector approached the resident who remained sitting in front of the nursing station and noted that there remained a foul odour from the resident. The Inspector encouraged the resident to stand and noted that the back of the resident's pants were soiled. A PSW who observed the Inspector and the resident, took the resident to their room and provided them with continence care.

Inspector #627 reviewed resident #032's care plan in effect at the time of the inspection and noted their continence care needs including but not limited staff to direct the resident to the toilet upon rising, before and after meals and at night time.

On August 18, 2017, Inspector #627 interviewed PSW #112 who stated that everyone had their briefs changed with morning care, however the rest of the day "did not work out often" in regards to continence care. They confirmed that residents #032, #021 and #007 had not been provided with continence care as they should have been.

On August 21, 2017, Inspector #627 interviewed PSW #114 who stated that residents were to be toileted and provided with continence care according to their care plans. They further stated that residents who were incontinent received brief changes when they were assisted to bed for naps. They further stated that residents should be checked for incontinence in the morning, before and after meals. It was reported to the registered staff and documented if a resident refused toileting assistance or a brief change.

On August 21, 2017, the Inspector interviewed Registered Nurse (RN) #113 who stated that residents were to be toileted and have their briefs checked or changed according to their care plan. RN #113 stated that it was disheartening that the above noted residents had not received continence care as stated in their care plan. They further stated that this was not acceptable and wished that staff had made them aware, so that they could have assisted them, and that this had to be addressed.

On August 21, 2017, the Inspector interviewed the Director of Care (DOC) who stated that it was the home's expectation that all residents received assistance with continence care to ensure they remained comfortable and dry, in order to protect their skin integrity, dignity and decrease behaviours. The DOC acknowledged that resident #007, #021 and #032 had not received assistance from staff for their continence needs.

The decision to issue this compliance order was based on the scope which was identified as a pattern, the severity which was indicated a potential for actual harm and the compliance history indicated one or more unrelated non-compliance in the last three years.
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 20, 2017

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. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee shall ensure that:

1) Corrective actions are taken to prevent medication patches to go missing.
2) An audit system is established to monitor the effectiveness of the corrective actions taken.
3) A written record is kept of the corrective actions and the results of the audit system.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that corrective action was taken in relation to all medication incidents and adverse drug reactions.

A Critical Incident (CI) report, was submitted to the Director. The CI report indicated that resident #021's medication patch went missing.

On August 22, 2017, during an interview with Inspector #609, the DOC stated that in 2016 there were three medication incidents whereby medication patches went missing. The DOC further indicated that in May 2017, three additional incidents of missing medication patches had occurred and that there was a trend in the home of missing medication patches.

A review of the home's policy titled "Medication Incident Reporting", last

reviewed 2017, indicated that reporting of incidents was for the purpose of evaluation in order to focus on process improvement and the reduction of future incidents.

During the same interview with the DOC, they verified that three times a day medication patch checks were implemented over a year ago in response to the missing medication patches and that it had not been effective in decreasing the incidents of missing medication patches in the home. The DOC indicated they had not put any other intervention or corrective action in place since the third incident of a missing medication patch in 2017, and was unsure what interventions could be implemented. They further indicated that they would reach out to other homes to develop and implement corrective actions to decrease the incidents of missing medication patches in the home.

On August 22, 2017, during an interview with Inspector #609, the home's Pharmacy Provider stated that they were not aware of the May 2017 missing medication patch incident and had they been made aware, they would have recommended that the home utilize two registered staff when performing the three times a day medication patch checks as a corrective action instead of one registered staff, as was the home's current practice. [s. 135. (2)] (609)

The decision to issue this order was based on the scope of this issue which was determined to have been a pattern, the severity was determined to be potential for actual harm and a compliance history indicating one or more unrelated non-compliance in the last three years.
(609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 20, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Order / Ordre :

The licensee shall prepare, submit and implement a plan of a process to ensure that residents residing on a specific unit, have their preferred bedtime supported and individualized

This plan shall be submitted in writing to Sylvie Byrnes, Long Term Care Homes Nursing Inspector, Long-Term Care Branch, 159 Cedar Street, Suite 403, Sudbury Ontario, P3E 6A5, or faxed to the Inspector's attention, at (705) 564-3133, or email SudburySAO.moh@ontario.ca. This plan must be submitted by October 13, 2017.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that each resident of the home had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

During a family interview, a complaint was voiced in regards to shortage of staff, which caused the resident to not receive appropriate care.

On August 21, 2017, between 1820 and 1830 hours, during a tour of a home area, Inspector #609 noted that many residents were in bed and that many of the residents had their night clothes on: resident #007, #020, #021, #032, #037, #038, #039, #044, #045, #046, #048, and #049.

On August 22, 2017, at 1820 hours, Inspector #627 completed further observations on the same home area and noted that 12 residents were in bed, in their night clothing: #020, #021, #032, #037, #038, #039, #040, #041, #042,

#044, #045 and #046.

Inspector #627 reviewed the care plans in effect at the time of the inspection for the above residents and noted that for residents #007, #020, #021, #032, #037, #038, #039, #040, #041, #042 and #044, a preferred bedtime was specified which was later than the observation of the Inspector. Residents #045, #046 and #049's care plans had not indicated a preferred bed time.

A review of the home's policy titled "Resident's Bill of Rights", last reviewed on January 2015, indicated that "a plan of care was a written document that said what kind of care a resident needed and how that care was to be provided. Your plan of care was unique to you".

On August 21, 2017, Inspector #609 interviewed PSW #119 who stated that in the past, the specific home area was staffed with a certain number of PSWs, however there was one less PSW now. This was challenging as many of the residents had responsive behaviours. The unit was too small and there was not enough room to manage all the residents. The residents gathered in front of the nursing station and became responsive towards each other. The evening shift now had to put away the laundry which was disturbing to the residents and took away from resident care.

On August 22, 2017, Inspector #627 interviewed PSW #124 who stated that after dinner, around 1800 hours, the residents who required to be transferred with a mechanical lift were provided with night time care and transferred to bed. The care was completed at this time as the unit had a lot of residents with responsive behaviours. Two staff members were required to monitor the ambulatory residents. The residents who required mechanical lifts were also transferred in bed for the night to offload pressure from sitting in a wheelchair.

On August 22, 2017, Inspector #627 interviewed PSW #120 who stated that after dinner, the PSWs transferred the residents who required mechanical lifts to bed and provided them with night time care. The PSW stated that these residents needed to go to bed first as they had big chairs, and there was no place to sit them on the unit.
They further stated that there were a lot of responsive behaviours on the unit which were challenging, and there was only so many PSWs to provide care. They further stated that two PSWs were required to transfer a resident with a mechanical lift, one PSW toileted the ambulatory residents and one PSW was

required to stay in the lobby to monitor the residents' responsive behaviours. PSW #120 stated they had not followed the residents' bedtime preference as this was not achievable, especially with the added duties such as putting laundry away and providing the nourishment pass. They further stated that they had done the best they could.

On August 23, 2017, the Inspector interviewed the DOC who stated that the home attempted to pay particular attention to the residents' sleep pattern and preference by indicating a range of the preferred bedtimes, and that the care plans were to be current. The DOC stated that it was not acceptable to have residents in bed at approximately 1830 hours, unless this was their preference. They further stated that the home was here for the residents and the care was to be resident focused, and that the care plans were to be followed including the residents' preferred bedtime routines.

The decision to issue this order was based on the scope of this issue which was determined to be a pattern, the severity was determined to be potential for actual harm, and the compliance history indicating one or more unrelated non-compliance in the last three years. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 20, 2017

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, commercial courier or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Sylvie Byrnes

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