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 prévue le Loi de 2007 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 Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 06, 2017;	2016_353589_0016 (A2)	023257-16	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

Midland Gardens Care Community
130 MIDLAND AVENUE SCARBOROUGH ON M1N 4B2

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

Ontario

Ministry of Health and Long-Term Care

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Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

JOANNE ZAHUR (589) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

A2 amendment completed related to rescinding compliance order #008 under s. 6 (4) as during the RQI the follow-up inspection to this legislation was inspected to be in compliance related to the grounds under which the order was issued. However during this RQI, findings of non-compliance remain under s. 6 (4) with different grounds and will be issued as a WN/VPC.

Issued on this 6 day of February 2017 (A2)

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

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

JOANNE ZAHUR (589) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 3, 5, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30, 31, September 1, 2 & 6, 2016.

The following critical incident reports were inspected concurrently with the Resident Quality Inspection (RQI): #013229-16, #008913-16, #011926-16, # 020411 -16, #0263371-16 and #020748-16 related to alleged staff to resident abuse, #017333-16 and #022999-16 related to continence care, dignity and choice, #023796-16 related to neglect, #023707-16 related to the prevention of abuse and neglect, #025871-16 related to alleged abuse by other person, #026274-16 related to continence care and neglect, #012134-16, #015826-16, #015292-16, #012138-16, #016968-16, #014768-16, #023943-16, #022029-16 and #012840-16 related to resident to resident abuse, #000747-16, #024529-16, #023821-15 and #022039-16 related to falls prevention.

The following complaints were inspected concurrently with the RQI: #009729-16 related to improper, rough care, #016275-16 related to skin & wound and falls prevention, #015376-16 related to housekeeping and maintenance, #023361-16 related to plan of care, alleged staff to resident abuse, #024904-16 and #024921-16 related to extreme heat in the home, #035017-16 related to skin & wound, and #014414-16 related to falls prevention, reporting and complaints and critical incident response.

The following compliance order follow-ups were inspected concurrently with the RQI: #019030-16 related to emergency plans, #020184-16 related to collaboration

and safe transferring, #020404-16 related to continence care assessments and analysis of every incident of abuse and #020403-16 related the cleanliness of the home, furniture and equipment.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director's of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Director of Dietary Services (DDS), Food Services Supervisor (FSS), Director of Resident Programs (DRP), Director of Environmental Services (DES), Resident Relations Coordinator (RCC), Dietary Aides (DA), Program Aide (PA), Housekeeping Aide (HA), Supervisor of Laundry Services (SLS), Housekeeping Supervisor (HS), Registered Dietitian (RD), Physiotherapist (PT), Residents' Council and Family Council Representatives and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, 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

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

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

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

28 WN(s)
14 VPC(s)
11 CO(s)
1 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 20. (1)	CO #901	2016_353589_0016	589
O.Reg 79/10 s. 229. (5)	CO #004	2016_226192_0013	512
O.Reg 79/10 s. 88. (2)	CO #003	2016_226192_0013	512

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. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee shall ensure the home’s Hot Weather - Management of Risk and Heat Contingency Protocols are implemented when a Humidex value is between 30 and 39.

The licensee has failed to ensure that the written hot weather related illness prevention and management plan for the home that meets the needs of the residents, was implemented to address the adverse effects on residents related to heat.

According to evidence-based practice titled "The Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care, July 2012", developed by the Ministry of Health and Long Term Care, routine checks to assess indoor air temperatures and Humidex levels at varying times throughout the day should be implemented. The guidelines include direction to monitor outdoor air temperatures and Humidex levels to determine when indoor values needed to be evaluated. Once a Humidex value is between 30 and 39, which is a zone where most individuals would feel some discomfort, staff would need to be informed to enhance their monitoring of residents who were assessed at high to moderate heat risk. In some cases, monitoring of residents with specific health conditions would need to be monitored at a Humidex as low as 32.

Review of home’s most recent policy titled Hot Weather-Management of Risk #VII-G-10.10 and Heat Contingency Protocols #VII-G-10.10 (a), stated that in the event of heat alert or heat wave, staff are required to close all curtained areas and windows during the day and shut off the lights that are not required to minimize heat. Maintenance is required to record indoor temperature and humidity percentage from various locations within the building daily and inform all departments of the heat contingency protocols to be implemented. The policy also required staff to receive annual education information on prevention and management of heat related illness and hot weather plans.

Review of the home's Heat Contingency Protocols policy revealed three threshold levels that include Summer Practice, Intervention Alert, and Emergency Alert. Each threshold level had specific interventions for residents identified as being as high heat risk.

Interventions included that staff are required to close all curtained areas and windows during the day, shut off the lights that are not required to minimize heat and move residents to designated cooling areas.

Review of the air temperature log on a specified date during the resident quality inspection (RQI) revealed the following air temperatures and humidity levels:
-on an identified nursing station was recorded at 30.3 degree Celcius and humidity at 64.4,
-on an identified nursing station was recorded at 30.3 degrees Celcius and humidity at 67.2.
The emergency threshold level is identified as an air temperature that is greater than 29 degrees Celcius.
Based on the home's Heat Contingency Protocols policy an emergency alert should have been in place at time of the inspection.

Interview with the staff #123 revealed that designated cooling areas in the home had been identified as the dining rooms located on each resident home area.

Interview with the staff #106 confirmed an emergency alert had not been communicated to staff in the home.

An observation by the inspector revealed resident #061 positioned in the common area by the nursing station. Resident #061 required supplemental breathing equipment and was complaining of feeling very hot. Resident #061's heat assessment score assessed them to be at risk.

An observation by the inspector revealed multiple residents positioned in the common area by the nursing station and in the east corridor. Four staff were observed seated in the designated cooling area. Further observations revealed resident #060 positioned in the common area by the nursing station with supplemental breathing equipment in place. Resident #060 was restless, sweating profusely and had dry lips. Staff serving nourishment passed by without offering any nourishment to resident #060. The inspector interviewed resident #060 with staff #121 as a translator. The resident stated that he/she was hot and thirsty. Inspector #502 requested that staff #121 provide fluid to resident #060. Further observations revealed that random resident rooms had open windows, curtains not drawn closed and a corridor window had a broken closing latch preventing it from closing properly.

Interviews with staff #122 and staff #120, #121 and #124 revealed that they were not aware of the heat related action plan that should be in place to address the heat condition. She/he revealed that the emergency alert had not been

communicated today. The inspector instructed staff to move residents into the dining room. Staff #122 revealed to the inspector that the air conditioning (AC) unit in the cooling area had not been working and the area was hot. Inspector #502 observed that the AC unit was working and brought the concern to staff #123's attention. He/she immediately informed all nursing staff to stop whatever they were doing and move the residents into the cooling area immediately. [s. 20. (1)]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 are kept clean and sanitary.

Compliance order CO#001 issued in April 2016, related to accommodations services-maintenance required follow-up during this RQI inspection.The order directed the home to ensure that all equipment required to provide resident care, shower rooms, walls, baseboards and windows in the home are kept clean and

sanitary and that monitoring processes are developed to maintain and monitor the cleanliness of all of these items. The home was to have been in compliance by a specific date in July 2016.

On multiple occasions during the RQI, the inspector made several observations and interviews with staff related to the cleanliness of the home.

An observation by the inspector revealed a dirty toilet bowl on the outside of the bowl near the bottom of a shared bathroom.

In an interview, staff #220 stated he/she had not been aware that the toilet bowl had been dirty and would notify housekeeping staff to clean it.

In an interview, staff #136 confirmed the toilet bowl was not cleaned and stated that the housekeeping aide should have cleaned the washroom including toilet bowl. [s. 15. (2) (a)]

2. Observations during the RQI revealed the base of a mechanical lift apparatus was observed to be unclean.

In interviews, staff #142 and #217 confirmed the mechanical lift apparatus had not been cleaned and the staff #142 stated that it should have been cleaned at the end of each use.

In an interview, staff #101 stated it is the home's expectation that PSW staff clean the mechanical lift apparatus to ensure it is kept clean and sanitary. [s. 15. (2) (a)]

3. Observations by the inspector revealed a window in the residents' library soiled with black debris, dust and dead insects between the screen and window pane and also in the main floor north and south stairwell which was accessible to residents.

In an interview, staff #106 confirmed the above observations and stated that the home had no working or preventative cleaning schedule in place for the interior of the windows in the common areas of the home accessible to residents. [s. 15. (2) (a)]

4. An observation conducted by the inspector revealed the top edge of the handwashing sink in the kitchen was covered with black and brown debris.

Staff #118 had been present during this observation and stated that he/she would look into having the sink cleaned.

The inspector conducted further observations in the kitchen and noted the hand washing sink in the same unclean condition.

In an interview, staff #103 confirmed the home's furnishings and equipment had not been kept clean and sanitary. [s. 15. (2) (a)]

5. The licensee has failed to ensure that there is cleaning schedule for all the equipment related to the food production system.

Observations in the kitchen were conducted as a follow-up to compliance order #001 issued in April 2016, under inspection number 2016_226192_0013.

Observations conducted by the inspector and staff #118 revealed the following:

-ceilings and walls of the walk-in fridge and freezers were unclean,
-walls that did not have boxes and crates with food items in front were unclean, and

-a panel inside the ice machine was also unclean.

In an interview, staff #118 agreed that the ice making machine needed to be cleaned.

Further observations of the kitchen conducted by inspectors #501 and #512 revealed the panel of the ice machine had been cleaned, however it still remained visibly unclean.

In an interview, staff #118 stated that the walk-in fridge and freezers had been last cleaned by a newly hired cook who had been brought in to do the cleaning. The cook had swept and mopped the floors of the fridge and freezers however the ceilings and walls had not been cleaned.

Staff #118 had been unable to provide a cleaning schedule to show that the ice making machine had been cleaned prior to this inspection.

In an interview, staff #225 stated the home had no cleaning schedules for the walk-in fridge, the walk-in freezers, and the ice machines. The home is currently working

to set up these cleaning schedules.

In an interview, staff #103 confirmed that there had been no cleaning schedules for equipment related to the food production system. [s. 15. (2) (a)]

6. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The MOHLTC ActionLine received a complaint related to the lack of maintenance in the home. The complainant reported that the tap in the dining room had fallen off in his/her hands when he/she had tried to turn the tap on.

During the RQI the inspector attempted to turn on the tap by a hand-washing sink beside the servery in a specified dining room. The inspector noted it had not remained totally secure to the actual faucet attachment. It was also observed that the tap remained operational as evidenced by running water out of the tap.

In an interview, staff #218 confirmed that he/she had washed his/her hands numerous times at this tap and was not aware that it was not secured to the base of the faucet.

In an interview, staff #106 stated that he/she had not received a request for the broken tap however he/she would look into it.

In an interview, staff #103 confirmed that the tap in the fifth floor dining room had not been maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

7. On multiple occasions during the RQI, inspector #502 and inspector #512 observed in an identified room a wall in disrepair with insulation material visible.

In an interview, resident #086 stated the wall had been in disrepair for a few months and he/she had reported this to the maintenance staff some time ago.

In an interview, staff #216 stated he/she had not been aware of the holes in the wall and had not received any report from PSW staff.

In an interview, staff #106 and staff #103 confirmed that the wall in an identified room had not been maintained in good state of repair. [s. 15. (2) (c)]

8. Observations conducted by the inspector on two identified dates noted the following in a specified room:

-chipped paint and multiple scratch marks at bottom of wall,
-two holes, each sized two inches in diameter in the corner and one near the baseboard on the wall,
-a light diffuser panel on the ceiling noted to have three blots of debris resembling dead insects in it,
-the faucet in the washroom running continuously with hot water which could not be turned off when tested and,
-a hole behind the toilet seat sized two inches in diameter, two ceiling tiles with water marks, dry wall peeled off in an adjacent area, and multiple scratch marks in the washroom.

In an interview, staff #222 stated the faucet had been leaking two weeks ago and had been repaired by maintenance. Staff #222 further stated that he/she had not been aware the faucet had been leaking for the past four days.

In interviews, staff #106 and staff #103 confirmed the walls, faucet, ceiling tiles and light diffuser panel had not been maintained in a good state of repair. [s. 15. (2) (c)]

9. The inspector observed the following in a specified room:

-wall paper peeled off three quarters of the length of the door height exposing dry wall underneath at the door way, and
-staples noted on wall paper which appeared to indicate previous attempts to fasten peeled off wallpaper to the wall.

In an interview, staff #100 stated that he/she had not been aware of the above mentioned areas of disrepair.

In an interview, staff #106 confirmed that the request for repairs had been received and that wall paper by the door frame had been in need of repair.

In an interview staff #103 confirmed that the above mentioned areas of disrepair had not been maintained in a good state of repair. [s. 15. (2) (c)]

10. Observations conducted by the inspector with staff #118 revealed the handwashing sink by the kitchen door had been covered with black and brown

debris along the top edge, and that part of the caulking had been missing.

In an interview, staff #118 stated that he/she will look into having the sink cleaned and would notify the maintenance department to replace the caulking.

Further observations by the inspector revealed the hand washing sink to be in the same condition as described above.

In an interview, staff #106 confirmed that he/she had not received a maintenance request for the hand washing sink in the kitchen.

The severity is potential for actual harm related to the ongoing uncleanliness of the home, and the scope is a pattern as numerous areas of the home were observed to be in a state of uncleanliness. Compliance history identified a compliance order had been served under O. Reg. 79/10 s. 15., in April 2016, with a compliance date in July 2016. Due to ongoing non-compliance with O. Reg. 79/10 s. 15. a compliance order is warranted. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 65. No interference by licensee
A licensee of a long-term care home,
(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;
(b) shall not prevent a member of the Residents' Council or Family Council from entering the long-term care home to attend a meeting of the Council or to perform any functions as a member of the Council and shall not otherwise hinder, obstruct or interfere with such a member carrying out those functions;
(c) shall not prevent a Residents' Council assistant or a Family Council assistant from entering the long-term care home to carry out his or her duties or otherwise hinder, obstruct or interfere with such an assistant carrying out those duties; and
(d) shall ensure that no staff member, including the Administrator or other person involved in the management or operation of the home, does anything that the licensee is forbidden to do under clauses (a) to (c). 2007, c. 8, s. 65.

Findings/Faits saillants :

1. The licensee has failed to ensure that the operation of the Residents' Council was not interfered with.

Record review of the Residents' Council meeting minutes for a four month period in 2016, revealed an election had been held on August 2016, to replace the former President of the Residents' Council.

Interviews were conducted with resident #080 on two identified dates. The resident told the inspector that an election had been held to replace the former President of the Residents' Council. Resident #080 further stated that four residents had been voted in, including him/herself and resident #081, who had been the Vice President previously. Resident #080 stated he/she had been told by staff #119 that he/she had received the most votes at the Residents' Council election and believed that he/she would be designated as the President of the Residents' Council.

In an interview, resident #080 stated that he/she had been the Vice President (VP)

of the Residents' Council for the last five years and believed that he/she would be the VP again for this new Residents' Council.

In an interview, staff #119 the Residents' Council assistant stated the Residents' Council had met after the election, and that residents had expressed an unwillingness to take on the responsibility of the designated roles including President and VP. Staff #119 further stated a representative from the Ontario Association of Residents' Council (OARC) had been booked to speak at a Residents' Council meeting about a new leadership model where all residents on the Council would work together instead of having designated roles. Staff #119 stated he/she had explained the new leadership model to the residents on the Council and they all had agreed to it.

Review of the Residents' Council meeting minutes for two months had not revealed any presentation made by OARC had included discussion on the new leadership model. The inspector requested the Residents' Council meeting minutes for a specific date to review. Review of the Residents' Council meeting minutes provided revealed in the "other", section, an entry recorded as: Election Outcome: Newly elected Resident Council Leadership team had been introduced as resident #081, resident #080 and two other co-residents. The New Leadership model had been explained as the elected team working together to meet the objectives of the Resident Council Executive, with no designated role (i.e. President, V. President etc.)

In interviews, resident #080 and resident #081 stated they could not recall any new leadership model having been discussed.

In an interview, staff #226 stated he/she had received a request from staff #119 to present the new leadership model to the home's Residents' Council. Staff #119 had expressed that the home's Residents' Council had been struggling as it had lost a few members recently. Staff #226 had not been aware that anyone on the Residents' Council had objected to taking on the individual officer roles within a Residents' Council nor did any residents voice any objections during the presentation.

In an interview, resident #080 further stated that at past meetings, the three co-residents on the Residents' Council had only expressed an unwillingness to take over the responsibility of looking after the Residents' Council funds. Resident #080 further stated he/she had been willing to take over the financial responsibility as

well.

In interviews residents #081 and #080 stated that staff #119 had met with the Residents' Council and resident #080 indicated the Council had been told that, "There is going to be no real structure any more. There is not going to be a president and a vice president. We were told that this direction had originated from the central Residents' Council Committee which oversees Residents' Councils in all the homes." Resident #081 indicated the reason for this new structure had been, "because we are short, we only have four on the council. We need to have five in the Residents' Council to have a president and vice president."

In interviews, the staff #119 and staff #103 stated there had been some miscommunication between the residents and the home. Staff #119 stated that maybe because he/she had only been on the job since the beginning of the year, the residents had misunderstood him/her.

In interviews, staff #119 and staff #103 confirmed that the operation of the Residents' Council had been interfered with by changing the structure of the Residents' Council without the involvement of the members of the Residents' Council after the Residents' Council held an election and established new executive.

The severity is minimum risk to potential for harm, related to confirmed licensee interference with the structure of the Residents' Council and residents' emotional response to the proposed change in the structure of the Residents' Council. The scope is widespread as it affects all residents. There is no previous compliance history related to s. 65. Due to the confirmed licensee interference with the structure of the Residents' Council, a compliance order is warranted.. [s. 65. (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The home received a compliance order that directed the home to ensure that staff use safe transferring and positioning devices or techniques when assisting residents who require assistance with transfers. The home was to be in compliance by April 2016.

The MOHLTC ActionLine received a complaint related to resident #027 sustaining an injury that the complainant believed had occurred in the home.

Review of resident #027's health record revealed that he/she was not able to be interviewed as he/she was no longer able to express him/herself.

Review of an individualized resident assessment revealed resident #027 had been able to maintain position and trunk control. Review of resident #027's plan of care which was after the alleged above mentioned incident revealed resident #027 now required two staff to provide extensive assistance for all mobility and positioning needs.

During the RQI, the inspector observed staff #162 transferring resident #027 without any assistance.

In an interview, staff #162 stated he/she would ask another staff member to assist with mobility and positioning needs of resident #027 only when required.

In an interview, staff #142 confirmed that staff had not used safe transferring and positioning devices or techniques when assisting resident #027.

The scope of this finding is isolated to one resident, the severity is a potential for harm. The previous compliance history revealed a compliance order had been left with a compliance date in April 2016. As a result of this ongoing non-compliance with O. Reg. 79/10, s. 36, a compliance order is warranted. [s. 36.]

Additional Required Actions:

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

WN #5: 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).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

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

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee 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.

The home received a compliance order which directed the home to ensure that resident #004 and every other resident who had been assessed to require mechanical transferring apparatus' also have their continence reassessed using an appropriate assessment instrument. The home was to be in compliance by June 2016.

Review of the home's Transfers Method – Mechanical Lift assessment with a completion of date June 2016, conducted by staff #128 revealed resident #004 required a mechanical transferring apparatus for transfers from one surface to another.

Throughout the Resident Quality Inspection (RQI) resident #004 was only observed seated in his/her own chair.

Review of the resident's #004's Continence/Bowel Assessment revealed resident #004 had been last assessed in April 2014, and had been continent of bladder and bowel at the time of this assessment.

Review of resident #004's RAI-MDS assessment dated June 2016, revealed resident #004 now was continent of bowel and incontinent of bladder. A reassessment of resident #004 had not been identified.

In an interview, resident #004 stated it usually takes multiple staff members to transfer him/her using a mechanical transferring apparatus onto a toileting aid twice daily at two specified times in the day.

In an interview, staff #161 stated that a clinically appropriate assessment instrument should be used to assess continence on admission and when the resident's status changed. He/she confirmed that resident #004's continence had not been reassessed when there had been a change in bladder continence.

In an interview, DOC #101 confirmed that compliance order #002 had not been

complied with. He/she also stated that the home had not been aware of the order. [s. 51. (2) (a)]

2. During an interview, resident #066 stated that after a specified amount of time he/she could feel that the incontinence care product was soiled and he/she had been uncomfortable. Resident #066 further stated that his/her incontinence care product was only changed once per shift, and that during the night shift he/she had not been changed or provided proper hygiene by staff #201. Resident #006 further stated he/she is usually told him/her to wait for the next shift due to lack of supplies by staff #201.

Review of resident #066's health record revealed that continence assessments had not been completed on admission nor up to the time of this inspection, using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

In an interview, staff #101 stated all residents should be assessed on admission, annually and when there has been a change in condition. He/she stated they were unaware as to why the resident had not been assessed using the above identified tool. [s. 51. (2) (a)]

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

The MOHLTC ActionLine received a complaint related to continence care for residents in the home. The complainant stated that resident #027 was transferred to his/her wheelchair and wheeled to the elevator while his/her incontinence care product and bed were visibly soiled.

The inspector observed staff #162 changing resident #027's incontinence care product in bed. In interviews, staff #162 and #195 stated that resident #027required to be changed in bed related to impaired mobility.

Review of resident #027's individualized resident assessment revealed resident #027 had been frequently incontinent of bowel and bladder, had been able to maintain their mobility as determined during a physiotherapy sitting balance test and had required extensive assistance of two staff for toilet use. Further review of resident #027's plan of care revealed resident #027 had cognitive loss related to an

underlying health condition which impaired decision making and the ability to communicate clearly. An individual toileting plan to promote and manage bowel and bladder continence had not been identified in the plan of care.

In an interview, staff #140 stated that resident #027's ability to request assistance with toileting had declined, but he/she would exhibit responsive behaviours when he/she needed to void or require a incontinence product change. Staff #140 also stated that resident #027 had been able to maintain continence of bowel and bladder if toileted, but an individualized toileting plan had not been developed for resident #027.

In an interview, staff #126 confirmed that resident #027 should have been toileted and that an individualized toileting plan had not been included in the plan of care. [s. 51. (2) (b)]

4. During an interview, resident #066 stated that after a specified amount of time the incontinence care product felt soiled and he/she would experience an unpleasant sensation. Resident #066 further stated that his/her incontinence care product is only changed once per shift and that during the night shift he/she had not been changed or provided proper hygiene by the staff #201. Resident #006 further stated that staff #201 usually tells him/her to wait for the next shift due to lack of supplies.The resident also stated he/she had regularly experienced infections.

Review of resident #066's most recent written plan of care revealed the resident is incontinent and staff are to ensure the resident is clean and dry at all the times. An individualized toileting plan had not been included in the plan of care.

In an interview, staff #201 stated that he/she had been usually changing the resident as per request, but that two to three times each month he/she would inform resident #066 of the lack of supplies and leave him/her to wait for the next shift to be changed.

In an interview, staff#126 confirmed that the resident should have been changed as needed and that an individualized toileting plan had not been included in resident #066's plan of care. [s. 51. (2) (b)]

5. The licensee had failed to ensure that the resident who is unable to toilet independently some or all of the time receive assistance from staff to manage and

maintain continence.

Review of a CIS report submitted to the MOHLTC, revealed that at a specified time resident #004 had requested assistance with toileting. The resident's family member and staff #156 had repeatedly requested to have resident #004 toileted by several staff members. The resident was eventually toileted two and half hours later.

Review of resident #004's individualized resident assessment revealed he/she had been continent of bowel and incontinent of bladder. The resident required the assistance of two staff for bed mobility and was totally dependent on two people for transfers and toilet use.

Review of resident #004's most recent written plan of care revealed the resident used a toileting aide requiring the assistance of two staff and that the incontinence care product was to be changed at specified times. Further review of the plan of care revealed the resident had been scheduled to be transferred to the toileting aide with a mechanical transferring apparatus at a specified time and whenever he/she requested.

In an interview, resident #004 stated he/she had been incontinent of urine and had been experiencing the urge to have a bowel movement. Resident #004 further stated he/she had informed staff #156 that he/she needed to be toileted and to call for staff assistance. Resident #004 stated that he/she was eventually toileted two and one half hours later at which time he/she had also been incontinent of bowel.

In an interview, staff #156 stated the following:
- at four specified times, staff #156 informed staff #129 that resident #004 needed assistance with toileting,
- at a specified time, staff #156 informed staff #161 that resident #004 needed to be toileted,
- at a specified time, the resident's POA informed staff #193 that the resident needed to be toileted,
- at a specified time, staff #156 observed staff #129 pouring water in the dining room, he/she informed him/her that the resident had been incontinent and required to be changed,
- staff #156 stated that resident #004 had told him/her to stop asking for assistance because staff never assisted him/her before the scheduled toileting time, and
- at a specified time, after dinner, resident #004 was toileted, washed and

transferred to bed.

In an interview, staff #129 stated that at specified time staff #161 told him/her that resident #004 needed assistance with toileting. Staff #129 also stated that staff #161 advised him/her to tell resident #004 that he/she had other residents to get out of bed and the resident had to wait until his/her assigned toileting time. Staff #129 also stated he/she informed resident #004 that other staff on duty were providing resident care and a second staff was needed for the resident's transfer to the toileting aide, however he/she believed nobody was willing to assist to toilet resident #004 as it takes an extended amount of time compared to other residents.

In an interview, staff #161 stated that he/she had informed staff #129 and staff #193 about resident #004's request to be toileted, but had not been aware that the resident had not been toileted as requested.

In an interview, staff #193 stated that he/she had told staff #129 to stop setting the dinner table and to toilet the resident right away, but staff #129 had ignored him/her.

In interviews, staff #126 and staff #101 confirmed that resident #004 had not received assistance from staff to manage and maintain continence. [s. 51. (2) (c)]

6. The licensee has failed to ensure that continence care products are not used as an alternative to providing assistance to toilet.

Review of a CIS report submitted to the MOHLTC, revealed that at a specified time resident #004 requested assistance with toileting. The resident's family member and staff #156 had repeatedly requested to have resident #004 toileted by several staff members. The resident was eventually toileted two and one half hours later.

In an interview, resident #004 stated that he/she had been toileted in the morning, and that no one had checked on him/her in the afternoon. The resident stated due to an identified medication that he/she urinated frequently and most of the time felt uncomfortable. The resident also stated that he/she had requested to wear two products to stay dry as when he/she requests to be toileted, he/she usually has to wait until his/her assigned time.

Review of the home's training material for bowel and bladder care titled: Tena Tips: Double Padding For Long-Term Care, revealed that double padding can increase

the risk for unnecessary discomfort and skin irritation.

In interviews, staff #110 and #129 stated that additional protection had been applied inside the resident's incontinent care product.

In interviews, staff #161 and staff #126 confirmed that the practice of additional protection had not been allowed in the home and staff had been directed to toilet residents more often instead of relying on the incontinent care products. [s. 51. (2) (e)]

7. A CIS report was submitted to the Ministry of Health and Long-Term (MOHLTC) related to residents not being treated with dignity and respect.

Review of the CIS report and home's investigation notes revealed resident #008 had requested assistance with toileting and that staff #155 had told resident #008 to void in their incontinent product. Resident #008 had told his/her spouse that he/she would not do that.

In an interview, staff #155 stated that he/she had told resident #008 to void in his/her incontinent product if staff were not available and he/she would not mind cleaning the resident later.

In an interview, staff #133 confirmed that staff #155 had told resident #008 to void in their incontinent product.

In an interview, staff #126 who is the continence lead confirmed the above mentioned incident and stated that staff had been advised to toilet residents more often and not to use the incontinent care product as a substitution to toileting.

The scope of finding is related to four residents, the severity is identified to be minimal or potential for actual harm in that residents expressed physical and emotional responses in relation to not being assisted with toileting. Previous history identified a compliance order had been served with a compliance due date in June 2016. Due to this ongoing non-compliance under O. Reg. 79/10. r. 51., a compliance order is warranted. [s. 51. (2) (e)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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 are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A CIS was submitted to the MOHLTC related to an incident of resident to resident aggression that had occurred on the same day.

Review of the CIS revealed that resident #013 had been seated in the dining room. When resident #013 had been directed by staff to move he/she struck resident #002 who had been sitting at the same table. The incident caused an injury to resident #002.

The CIS further revealed that resident #013 had been exhibiting responsive behaviours that day.

Review of the progress notes between an identified six month period revealed resident #013 had been exhibiting multiple incidents of responsive behaviours daily.

Review of resident #013's most recent written plan of care revealed that a responsive behaviour observation monitoring form was to be completed each shift for any responsive behaviours exhibited.

In an interview, staff #101 stated that resident #013 had a history of exhibiting responsive behaviours and the home had initiated one-to-one (1:1) monitoring on previous occasions. Staff #101 stated that 1:1 monitoring had been in place over the following time frames related to responsive behaviours:
-on identified dates between December and February 2016,
-on identified dates in May 2016; and
-from an identified date in July 2016, to present.

Review of progress notes for resident #013 revealed that at the time of the above mentioned incident there had not been any 1:1 monitoring in place, however this intervention had been re-initiated after the above mentioned incident.

In an interview, staff #101 stated that 1:1 monitoring had been re-initiated on an identified date in May 2016, after an incident had occurred between residents #013 and #014 and again after the above mentioned incident between residents #013 and #002. Staff #101 further stated that the documentation of registered staff had normalized resident #013's responsive behaviours.

In an interview, staff #100 stated that the registered staff had been responsible to ensure the responsive behaviour form had been completed every shift by the staff member assigned to 1:1 monitoring. Staff #101 further stated that by not consistently ensuring the completion of the responsive behaviour form he/she had fallen short of fulfilling his/her responsibility in identifying any risk of altercation and potentially harmful interactions between resident #013 and other residents.

In an interview, staff #101 confirmed that normalizing resident #013's responsive behaviours had failed to ensure that steps had been taken to minimize the risk of altercations and potentially harmful interactions between resident #013 and other residents by identifying and implementing interventions.

The severity of this finding is identified as actual harm, the scope is isolated to one resident and the previous compliance history identified a previous written notice with a voluntary plan of correction had been issued. As a result of this ongoing non-compliance with O. Reg. 79/10, s. 54(b), a compliance order is warranted. [s. 54. (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home was undertaken promptly after the licensee becomes aware of it.

A CIS report was submitted to the MOHLTC related to a complaint about alleged staff to resident abuse. The CIS revealed that resident #007 reported that an evening staff member had spoken to him/her in a discourteous manner and that he/she was no longer comfortable receiving care from this particular staff member.

Review of the home's Complaints and Concerns binder revealed that an analysis of this complaint had not been undertaken.

In an interview, staff # 123 confirmed the home had not undertaken an analysis of the above mentioned complaint as they had focused on the staff's non-compliance related to the above mentioned incident.

The severity of this finding is minimal risk, the scope is isolated to one resident and the previous compliance history identified a previous compliance order had been served with a compliance date in June 2016. As a result of this ongoing non-compliance with O. Reg. 79/10, s. 99(a), a compliance order is warranted. [s. 99. (a)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. The licensee shall ensure that following emergency plans are tested every three years and that a written record is kept of the completed tests dentifying changes made to improve the following plans:
- emergency evacuation plan, and
- bomb threat plan.

In April 2015, the home received a compliance order related to testing the emergency plans during a critical incident inspection. The order indicated the home was to be in compliance by an identified date in March 2016.

In June 2016, the home received a second compliance order related to testing the emergency plans during a follow-up inspection. The order indicated the home was to be in compliance by an identified date in July 2016.

Record review of the home's emergency binder revealed the emergency evacuation plan and the bomb threat plan had not been tested as per the two identified compliance orders.

During interviews conducted on two identified dates in September 2016, with staff

#106 and staff #103 respectively, both confirmed that the home's emergency evacuation plan and bomb threat plan had not been tested.

A Mock Evacuation Project "Code Green" plan was provided to the inspector by staff #103. Staff #103 stated that the home has been scheduled to complete the test of the emergency evacuation plan on an identified date in October 2016. Staff #103 stated that all community agencies, including local fire department, police department, and emergency medical services had not been invited to participate by the date of this inspection.

Staff #103 also stated that the goal for the home had been to test the bomb threat plan by an identified date in October 2016, before accreditation takes place in the home; however a plan was not provided to the inspector to support this statement.

The scope of this finding had been identified in two previous inspections and therefore is a pattern. The severity is a potential for harm, and the previous compliance history revealed that a compliance order had been served with a compliance date in March 2016, and in June 2016 a second compliance order with a compliance date in July 2016, had been served due to ongoing non-compliance. As a result of two previous compliance orders having been served and continued non-compliance with O. Reg. 79/10 r. 230 (7), a Director's Referral is warranted. [s. 230. (7)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

s. 6. (6) When a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44. 2007, c. 8, s. 6 (6).

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 :

(A2)
1. The licensee has failed to ensure that the care plan sets out clear directions to staff and others who provide direct care to the resident.

The MOHLTC ActionLine received a complaint related to a family member's concern regarding resident #024's risk for falls.

In an interview, the complainant stated resident #024 had experienced a fall after being left in the room unattended.

In an interview, staff #184 stated resident #024 was positioned near the nursing station so staff could monitor him/her closely. Staff #184 further revealed that resident #024 requires to be repositioned frequently related to impaired mobility. Staff #184 stated that he/she had not been aware why resident #024 had been left unattended his/her room.

Review of resident #024's most recent written plan of care revealed resident #024 had been identified at high risk for falls, the goal was to be free of falls, and interventions were to review information on past falls and attempt to determine the cause of falls. Staff to remove any potential causes if possible.

In an interview, staff #185 stated there had not been enough interventions in the written plan of care to identify what they were planning to do in order to prevent resident #024 from experiencing falls.

In an interview, staff #185 confirmed the interventions in resident #024's written plan of care had not provided clear directions to staff and others who provided direct care to resident #024. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

The MOHLTC ActionLine received a complaint related to continence care for residents in the home.

The inspector observed staff #162 changing resident #027's incontinent care product in bed.

Review of resident #027's individualized resident assessment revealed resident #027 had been frequently incontinent of bowel and bladder, he/she was able to maintain their mobility and required extensive assistance of two staff for toilet use. Further review of resident #027's plan of care revealed resident #027 had cognitive loss related to an underlying health condition which had impaired decision making and the ability to communicate clearly. An individual toileting plan to promote and manage bowel and bladder continence had not been identified in the plan of care.

In interviews, staff #162 and #195 stated that resident #027 required their continence care to be provided in bed related to impaired mobility.

In an interview, staff #140 stated that resident #027's ability to request for assistance with toileting had declined but he/she would exhibit responsive behaviours when he/she needed to toilet. Staff #140 further stated that to prevent resident #027 from falling, the full-time evenings staff would toilet resident #027 using a toileting aid at specified times. Staff #140 also stated that the above mentioned toileting care needs had not been included in resident #027's written plan of care nor had been shared with other team members.

In an interview, staff #126 confirmed that the care set out in the plan of care had not been based on an assessment of the resident and the needs and preferences of resident #027. [s. 6. (2)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that different aspects of care are consistent with and complement each other.

A CIS report was submitted to the MOHLTC related to abuse of resident #065 by an identified person.

A review of the CIS report, resident #065's progress notes and the home's visitor sign-in sheet, all revealed that the identified person had visited the resident on

multiple occasions.

The following incidents occurred during the visits:
-staff #195 heard resident #065 telling the identified person to stop. Staff #195 entered the room and observed the identified person abusing the resident, and
-the next day the identified person visited again and denied having visited the day before.

After the above mentioned incident had occurred the following interventions were put in place to protect resident #065 from any potential abuse:
-ensure each visit took place in a common area and a staff member supervised the visit, and
-assess resident #065 after the visit for any sign of trauma.

In interviews, staff #139 and #219 confirmed that they had not been aware of any interventions that had been in place to protect the resident #065.

In an interview, staff #101 stated that following the alleged abuse, the authorities had informed the home they should allow the identified person to visit, and to contact the them as soon as he/she had entered the home. Staff #101 also confirmed sending an email to all nurse managers and ADOCs directing the nurse manager working during an identified weekend, that if the identified person visited the home, confirm his/her name, allow him/her to stay, and then to call the authorities.

Review of the resident's most recent written plan of care revealed there were no long-term interventions identified beyond the identified weekend and no interventions for front line staff if they were to observe the identified person on the unit in the nurse manager's absence.

A review of resident #065's progress notes revealed that on a specific date the identified person visited holding a document for the resident to sign. A family member had been informed and stated the identified person should be kept away from resident #065.

In an interview, staff #220 stated that the above mentioned request from the family member had been relayed to him/her by the previous shift nurse; he/she documented the information in the progress, but had not communicated this information to the management team.

In an interview, staff #101 stated he/she had not been aware of the family member's instruction following the visit by the identified person. Staff #101 further stated that if he/she had been aware of the family member's request, he/she would have followed the home's procedures and worked with the family member and the authorities.

Staff #101 confirmed that by not sharing information needed to protect resident #065, staff had not collaborated with each other in the implementation of the plan of care.

4. The licensee failed to ensure that within the times provided for in the regulations, the resident is assessed and an initial plan of care is developed based on that assessments and on the assessment, reassessments and information provided by the placement co-ordinator under section 44.

A CIS report was submitted to the MOHLTC related to abuse of resident #065 by an identified person.

Review of the admission record revealed that the identified person had misused resident #065's finances. Further review revealed the authorities had requested to be notified the next time the identified person visited.

In an interview, staff #200 stated that when resident #065 had been admitted to the home he/she had become aware of the above mentioned information but had not included that information in the initial plan of care.

A review of the CIS report, resident #065's progress notes and the home's visitor sign-in sheet, all indicated that the identified person had visited the resident on multiple occasions and abused the resident on at least one occasion.

In an interview, staff #101 stated that the authorities had informed the home they had been looking for this identified person, the home should allow him/her to visit, but to contact the authorities as soon as he/she entered the home.

In an interview, staff #101 confirmed the above mentioned information should have been included in the resident's initial care plan when admitted. [s. 6. (6)]

5. The licensee has failed to ensure that the care set out in the plan of care had

been provided to the resident as specified in the plan.

A CIS report was submitted to the MOHLTC revealed resident #022 sustained an injury after a fall that required a transfer to hospital for further assessment.

Further review of the CIS revealed that resident #022 had falls prevention interventions in place prior to the fall included:

Immediate actions to prevent recurrence included identified falls prevention interventions specific to resident #022.

Review of the most recent written plan of care revealed a falls risk focus that identified resident #022 at high risk for falls. The plan of care was updated to include the above mentioned immediate actions to prevent recurrence of falls. Review of the kardex located on the point of care (POC) screens accessed by staff revealed under the safety focus to put into place identified falls prevention interventions.

On two identified dates in August 2016, observations by the inspector revealed resident #022 was lying in bed with no identified falls prevention interventions in place.

In interviews, staff #140 and #139 stated that the above mentioned falls prevention interventions had not been in place.

In an interview, staff #138 confirmed that the care set out in the plan of care had not been provided as specified in the plan. [s. 6. (7)]

6. On an identified date in August 2016, observation by the inspector revealed that resident #050 was being assisted with feeding by staff #163. Resident #050 was observed to be in a reclined position while being fed. Subsequent observations by the inspector revealed that resident #050 continued to be assisted with feeding by staff #102 while he/she was seated in a reclined position.

Record review of resident #050's most recent written care plan revealed he/she required total assistance from staff for eating, and was at high risk for aspiration. Resident #050 was to remain seated upright during and thirty minutes after meals. Resident #050's diet order included that he/she was to be fed a specific amount at a time.

In an interview, staff #111 stated this was not the correct feeding position as per resident #050's written plan of care and that he/she should have been positioned in an upright position while being fed.

In an interview, staff #101 confirmed that by feeding resident #050 in a reclined position, staff #102 and #163 had not been providing care as set out in the plan of care. [s. 6. (7)]

7. A CIS report was submitted to the MOHLTC which revealed resident #021 had experienced a fall sustaining an injury.

Further review of the CIS revealed the night staff had been dressing the resident before the day staff started their shift and had been applying the body protectors bilaterally to identified areas of resident #021's body. The CIS also revealed resident #021 had been unsettled that morning prior the fall and had undressed him/herself on several occasions requiring staff to repeatedly dress him/her. However no one had checked to ensure the body protectors remained in place each time resident #021 had been re-dressed.

Review of resident #021's most recent written plan of care revealed the resident had been identified at high risk for falls and that one of the interventions was to have body protectors applied to decrease fall-related injury.

Review of the Post Fall Huddle revealed that at the time of the fall resident #021 had not been wearing body protectors as indicated in the written plan of care.

On an identified date in August 2016, observations by the inspector revealed resident #021 did not have body protectors in place.

In an interview, staff #149 stated he/she had been aware of resident #021's plan of care directing the staff to apply body protectors to prevent injury. Staff #149 further revealed resident #021 had been dressed by the night staff and that he/she had just changed the resident once at an identified time.

In an interview, staff #149 stated that when he/she had changed resident #021 he/she noted the body protectors had not been applied, however he/she still seated resident #021 in a mobility aid.

In an interview, staff #113 stated resident #021 had been identified at risk for falls and he/she was to have body protectors applied to decrease fall-related injury. Staff #113 further confirmed that body protectors had not been applied and that staff #149 had not provided care to resident #021 as per the plan of care.

In an interview, staff #138 confirmed that staff had not provided care to resident #021 as per the plan of care. [s. 6. (7)]

8. The licensee has failed to ensure that the provision of care set out in the plan of care had been documented.

A CIS report was submitted to the MOHLTC related to resident to resident physical aggression. The CIS revealed that resident #013 had seated him/herself at resident #002's table. When resident #013 was asked to move by staff he/she threw a plastic object at resident 002 causing an injury. The CIS further revealed that prior to this incident resident #013 had been exhibiting responsive behaviours.

Review of the most recent written plan of care revealed that individualized increased monitoring had been discontinued on an identified date in May 2016. After the above mentioned incident, individualized increased monitoring was re-initiated with responsive behaviour monitoring to be completed every shift.

Review of the responsive behaviour monitoring forms from an identified period revealed many gaps where the forms had not been completed every shift.

In interviews, staff #172 and #100 stated it is the responsibility of the individualized increased monitoring staff member to complete the responsive behaviour monitoring form every shift and registered staff are to check them at the end of their shifts to ensure for completion. Staff#100 further stated he/she had not been monitoring the responsive behaviour monitoring forms for completion resulting in a shortfall of his/her responsibility.

In an interview, staff #101 confirmed that inconsistent documentation in the responsive behaviour monitoring tool failed to ensure that the provision of care set out in the plan of care for resident #013 had been documented. [s. 6. (9) 1.]

9. A CIS was submitted to the MOHLTC related to resident to resident aggressive behaviour. The CIS revealed resident #017 had been heard exhibiting responsive behaviours towards another resident.The CIS further revealed that no one had

been present in the dining room to have witnessed resident #018 touch resident #017. Resident #017's medical history included underlying health conditions, a history of exhibiting responsive behaviours towards other residents and staff.

Review of the most recent written plan of care included the following interventions:
-individualized increased care and monitoring in place every shift,
-responsive behaviour monitoring every shift,
-divert attention with small talk or with activities or with watching ethnic movies on personal movie player,
-assist him/her to make phone calls to family,
-provide space,
-re-approach at a later time if in a bad mood when waking up in the morning,
-encourage to express feelings and,
-provide reassurance.

Review of the responsive behaviour monitoring tool from an identified date in August 2016 to present revealed the documentation had been incomplete on multiple dates throughout August 2016.

In an interview, staff #214 stated it is the responsibility of the one-to-one (1:1) staff member to complete the responsive behaviour monitoring tool and confirmed that it had not been consistently completed.

In an interview, staff #210 stated and confirmed it is the responsibility of the charge nurse to ensure that the staff member assigned to 1:1 had completed the responsive behaviour monitoring form every shift. Staff #210 further stated that staff #138 had recently provided education on the responsive behaviour monitoring tool and the responsibility of the registered staff and PSW's to ensure completion of this form.

In an interview, staff #138 confirmed that inconsistent documentation of the responsive behaviour monitoring tool failed to ensure that the provision of care set out in the plan of care had been documented for resident #017. [s. 6. (9) 1.]

10. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

During the inspection of an alleged abuse complaint resident #024 was observed wearing an identified incontinence care product

In an interview, staff #184's stated resident #024 had required a specified incontinence care product.

Review of resident #024's written plan of care revealed resident #024 had to be changed regularly and staff were to use an alternate size of incontinence care product.

In an interview, staff #185 stated the incontinent product worn by resident #024 had not matched the size of the incontinent product identified in the written plan of care. Staff #185 had not been aware why resident #024 had been wearing a different size of incontinent product and not the size that was indicated in the written plan of care.

After staff #185 spoke to staff #184 it was revealed that resident #024 had required an alternate incontinent product. Staff #184 confirmed resident #024's written plan of care had not been updated to reflect the change in resident #024's incontinence care product needs.

In an interview, staff #101 confirmed that the care plan had not been reviewed and revised when the resident #024's continence care needs changed. [s. 6. (10) (b)]

11. During the transition of stage one into stage two of the RQI, resident #036 triggered Bedfast through the resident assessment instrument.

Review of resident #036's health record revealed he/she had been admitted on an identified date in January 2016.

Review of resident #036's resident assessment instrument revealed the resident's physical functioning was totally dependent with two-person physical assistance for his/her ADL's. The resident had been described as having no mobility and requiring the use of a mechanical apparatus for transfers. Resident #036 had been bedfast all or most of time.

Observations of resident #036 conducted by the inspector revealed the resident was getting out of bed and transferred into a wheelchair before lunch and stayed up until after dinner on a daily basis.

In an interview, resident #036 stated that he/she had experienced altered skin integrity and had been in bed most of the time. The altered skin integrity was now healed and resident #036 had been getting up daily in his/her mobility aid.

In interviews, staff #104 and #146 stated resident #036 had been bedfast post admission related to impaired skin integrity. Currently the altered skin integrity was healed and that resident #036 had been getting up on a daily. Staff #104 and #146 both stated that the current written plan of care had not been revised.

In an interview, staff #101 confirmed that the care plan had not been reviewed and revised when the resident #036's care needs had changed.

The severity of this non-compliance is potential for harm related to improper feeding positioning, care not provided as per the plan of care, and plan of care not revised when the resident care needs of five identified residents changed. The scope is a pattern as five residents were identified, and previous compliance history identified a compliance order under the LTCHA 2007, s. 6. had been served with a compliance date in February 2016. As a result of ongoing non-compliance with O. Reg. s. 6., a compliance order is warranted. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 008, 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been rescinded:CO# 008

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 in the following:
-to ensure that the care plans set out clear directions to staff and others who provide direct care to the resident,
-that within the times provided for in the regulations, the resident is assessed and an initial plan of care is developed based on that assessments and on the assessment, reassessments and information provided by the placement co-ordinator under section 44,
-to ensure that the provision of care set out in the plan of care had been documented,
- to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, and
-to 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents are free from neglect by the licensee or staff in the home.

1. A CIS report was submitted to the MOHLTC related to resident neglect.

Review of the CIS report revealed that resident #004 had requested assistance with toileting. The resident's family member and private care giver repeated the request to toilet resident #004 on numerous times between identified hours to

several staff members. Resident #004 eventually was toileted two and one half hours later.

Review of the resident assessment instrument revealed resident #004 was continent of bowel and incontinent of bladder. Resident #004 required extensive assistance from two staff for identified ADL's.

Review of resident #004's written plan of care revealed resident #004 had used a toileting aid requiring the assistance of two staff. The plan of care also revealed that resident #004's incontinence care product had to be changed at two specified times during the day shift and a specified time in the evening shift with the aid of a mechanical apparatus.

In an interview, resident #004 stated he/she had experienced urinary incontinence and had been experiencing the urge to have a bowel movement. Resident #004 further stated he/she had informed staff #156 that needed to be toileted and to call for staff assistance. Resident #004 stated that he/she was eventually toileted two and one half hours later at which time he/she had also been incontinent of bowel.

In an interview, staff #156 stated the following:
-staff #156 informed staff #129 that resident #004 needed assistance with toileting on four identified times,
-staff #156 informed staff #161 at a identified time that resident #004 needed to be toileted,
-the resident's family member informed staff #193 at an identified time that the resident needed to be toileted,
-staff #156 observed staff #129 pouring water in the dining room, and informed him/her at an identified time that the resident had been incontinent of bladder and bowel and required to be changed prior to dinner,
-staff #156 stated that resident #004 had told him/her to stop asking for assistance because staff never assisted him/her before the scheduled toileting time, and
-at an identified time after dinner, resident #004 was toileted, washed and transferred to bed, which was two and half hours after the initial request for assistance.

In an interview, staff #129 stated that staff #161 had informed him/her that resident #004 needed assistance with toileting. Staff #129 also stated that staff #161 had advised him/her to tell resident #004 that he/she had other residents to get out of the bed and that resident #004 would have to wait until his/her assigned toileting

time. Staff #129 stated he/she had informed resident #004 that other staff members on duty were providing showers to residents and a second staff was needed for his/her transfer to the toileting aid, however staff #129 believed nobody was willing to assist as it takes at least an hour to toilet this resident.

In an interview, staff #161 stated that he/she had informed staff #129 and #193 about resident #004's request to be toileted, but had not been aware that resident #004 had not been toileted as requested.

In an interview, staff #193 stated he/she had told staff #129 to stop setting the dinner table and to toilet resident #004 right away, but staff #129 had ignored him/her.

Interviews with staff #126 and #101 confirmed that resident #004's toileting care needs had been neglected. They further stated that staff #129 had been disciplined regarding the above mentioned incident [s. 19. (1)]

2. A CIS report was submitted to the MOHLTC related to staff to resident abuse.

In an interview, resident #006 stated that he/she had requested staff #137 to wash him/her properly using a basin, with warm, soapy water and a towel. Staff #137 told the resident that the basin was in the washroom and he/she did not have the time to get it. Staff #137 then got a damp towel, wrung it out and wiped resident #006 with it. He/she then asked the resident to turn around and used the same dirty towel to wipe him/her again. Resident #006 also reported that staff#137 had provided improper morning care on other occasions and that he/she had apologized, however resident #006 was pleased that staff #137 no longer provided care to him/her.

In an interview, staff #137 stated he/she had not used the basin as per resident #006's request. Staff #137 also stated he/she had not known that not using the basin would hurt resident #006's feelings and had apologized to the resident.

In an interview, staff #101 confirmed that staff #137's action had been deemed inappropriate and unprofessional, and that resident #006 had been emotionally affected by the PSW's action. [s. 19. (1)]

3. A CIS report submitted to the Ministry of Health and Long Term Care (MOHLTC) revealed that resident #052's family member had reported that resident #052 was

abused by staff #188.

Record review of the interdisciplinary care conference notes (ICCN) revealed that resident #052 was cognitively intact.

In an interview, resident #052 revealed he/she had been abused by staff #188.

In an interview, resident #052's family member revealed he/she had witnessed staff #188 abuse his/her spouse.

In an interview, staff #188 denied the allegation that he/she had abused resident #052.

In an interview, staff #103 stated that had the alleged actions taken place, would have constituted abuse by the definition set out by the Regulations; however he/she denied that the licensee had failed to protect resident #052 from abuse.

In interviews, resident #052 and resident #052's family member revealed there had been two incidents of abuse of resident #052 by staff #188. In this case the licensee failed to ensure that resident #052 was protected from abuse by anyone. [s. 19. (1)]

4. A CIS report submitted to the MOHLTC revealed that resident #002 had been verbally abused by staff #209. The CIS revealed that when resident #002 had asked for assistance with his/her meal, staff #209 replied using inappropriate language and comments and leaving the room without assisting resident #002. The CIS further revealed resident #002 cognitively intact.

In an interview, resident #002 stated that he/she had sustained an injury that had impaired his/her mobility. Prior to the injury resident #002 had been mobile with a mobility aid and required one person assist for transfers, and was independently taking all meals in the dining room. As a result of the injury resident #002 had been taking meals in his/her room.

Resident #002 had been experiencing weakness in an identified body area and had asked staff #209 for some assistance with his/her meal tray. Resident #002 further stated that sometimes when staff #209 talks, it sounds inappropriate, and that sometimes he/she is very good but other times is not.

Review of home's investigation notes revealed that in an interview resident #002 had further revealed staff #209 told him/her to feed him/herself as he/she was not injured.

In an interview, staff #209 denied that he/she had spoken to resident #002 as described above and stated that he/she never would speak to any resident in that way.

Review of staff 209's personnel file revealed he/she had previously received disciplinary action for speaking inappropriately to a resident.

In an interview, staff #101 stated that as a result of the home's investigation and staff #209's prior disciplinary history, he/she would be given further disciplinary action related to this incident. Staff #101 confirmed that resident #002 had not been protected from abuse. [s. 19. (1)]

5. A CIS report submitted to the MOHLTC revealed that resident #019 had complained to staff #126 that a dressing he/she required was not being changed frequently. The CIS further revealed that staff #207 became upset when staff #126 reminded him/her to complete the dressing change as he/she stated that the dressing change was always completed when he/she was on shift. The CIS also revealed that resident #019 stated to staff #126 that staff #207 had spoken inappropriately towards him/her had made him/her feel guilty for complaining that some nurses were not completing the dressing changes.

In an interview, resident #019 stated that staff #207 had changed the dressing time to day shift from evenings. Resident #019 further revealed that he/she was absent from the home two to three times per week and preferred to have the dressing changed on evening shift, and that staff #207 walked out of the resident’s room without listening to his/her request to keep the dressing changes on the evening shift.

In an interview, staff #126 confirmed the above mentioned complaints voiced by resident #019.

Review of the most recent written plan of care revealed that resident #019 was cognitively intact.

Review of the treatment administration records (TAR) revealed that the dressing

had been completed daily on the evening shift except for a specific date in July 2016, where it had been completed on day shift. Further review of the TAR revealed the dressing had been changed back to the evening shift.

In an interview, staff #207 stated that he/she thought since resident #019 was bathed on the day shift, the dressing should be changed then. Staff #207 further stated that he/she had not been aware that resident #019 had not wanted the dressing time changed and admitted he/she had made a mistake. Staff #207 denied in an interview that he/she actions had been inappropriate or that he/she had spoke inappropriately to resident #019.

Review of the home's internal investigation notes revealed that resident #019's complaint had been verified and that the home had issued disciplinary action to staff #207.

In an interview, staff #101 confirmed that resident #019 had not been protected from verbal abuse.

The severity of this non-compliance is potential for actual harm related to residents' emotional well-being, dignity and respect, incidence of verbal abuse and inappropriate touching, the scope is a pattern as relates to five incidents reviewed in this inspection. Previous compliance history includes a written notice with a voluntary plan of action was issued. As a result of ongoing non-compliance with O. Reg., s. 19., a compliance order is warranted. [s. 19. (1)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #11: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. A CIS report was submitted to the MOHLTC related to the lack of continence care for resident #003.

The CIS revealed on two separate occasions resident #003 had requested to have his/her continence needs addressed. On the first occasion the incontinence product was changed however the bed linens were not and the resident was left in a soiled bed. On the second occasion the incontinence product was changed, the bed protector was removed and not replaced.

Review of resident #003's most recent written plan of care revealed the resident had been continent of bowel and frequently incontinent of urine. He/she had required assistance from one staff for identified ADL's.

In an interview, resident #003 stated that he/she had been left to sleep on a soiled pad on one occasion, and without a protective pad on a second occasion.

In an interview, staff #121 stated at that at the beginning of his/her day shift, resident #003 had informed him/her what had occurred during the night shift. Staff #121 confirmed that the resident's bedding had been soiled.

In an interview, staff #203 confirmed that resident #003 had rang the call bell on the above mentioned incidents. Staff #203 had changed the resident as requested but denied leaving the protective pad and bed linen unchanged on both nights.

In an interview, staff #101 confirmed that the above mentioned incidents had occurred as described and that staff #203 had been disciplined. Staff #101 further stated that resident #003's right to be properly cared for in a manner consistent with his or her needs had not been fully respected. [s. 3. (1) 1.]

2. A CIS report was submitted to the MOHLTC related to a witnessed incident of staff to resident verbal abuse.

The CIS revealed that staff #204 had witnessed an incident of staff to resident verbal abuse while standing in the back of the elevator. The following sequences of events were documented in the CIS:

-resident #085 came into the elevator at the ground level of the home with his/her 1:1 staff #215.
-staff #202 was standing close to the elevator control panel.
-resident #085 asked staff #202 to press an identified floor button and the staff member refused.
-resident #085 made a second request and staff #202 refused,
-staff #202 continued to make inappropriate remarks to resident #085 and tried to touch an identified body ares of resident #085 which he/shet disliked.
-staff #215 also made inappropriate remarks about resident #085's behavior which further provoked the resident.
-resident #086 raised his/her voice at the staff members using inappropriate words,

-staff #202 exited the elevator and said "thank you" loudly before he/she exited.
-resident #086, staff #215, and #204 remained in the elevator to the top floor. Upon exiting the elevator staff #215 spoke inappropriately to resident #086 while directing him/her to his/her room.
-staff #204 reported the incident to the staff #101 immediately.
-An investigation was initiated by the home during which the two staff members were identified and interviewed.
-As a result of the home's investigation, staff #202 and #215 were disciplined.
-staff#204 provided support to the resident following the incident.

In an interview conducted by the inspector, resident #086 declined to reveal details of the incident exhibiting a responsive behaviour.

In an interview, staff #221, who had been the individualized increased monitoring staff stated resident #086 exhibits responsive behavior if he/she was not able to obtain cigarettes and if provoked. Staff #221 further stated he/she had no issues providing care to resident #086.

In interviews, staff #202 and #215 both denied provoking resident #086, as

witnessed by staff #204.

In an interview, staff #204 reaffirmed that staff #202 and #215 had provoked resident #086 to the point where he/she verbalized profanity towards the two staff members and that resident #086 had not been treated with courtesy and respect.

In interviews, staff #123 and #101 confirmed resident #086's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity had not been fully respected and promoted. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the residents' right
- to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, and
- to be properly cared for in a manner consistent with his or her needs is fully respected and promoted, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, 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.

Observation conducted by the inspector revealed that in a damaged garbage can in a shared washroom.

In an interview, staff #220 stated he/she had not been aware of the damaged garbage can. Staff #220 further stated he/she would contact maintenance.

In an interview, staff #106 confirmed that the home had not provided a safe environment for the residents.

Observation by the inspector revealed the broken garbage can had been removed and replaced. [s. 5.]

2. Observations conducted by the inspector revealed that the door handle and key pad on an identified shower room was broken and could not be locked. A bottle of a cleaning disinfectant was observed stored on a wall shelf inside the shower room.

In an interview, staff #142 stated the door handle and key pad had been broken for a while and maintenance had been made aware of the issue. Staff #142 further stated he/she had not been aware of why the bottle of cleaning disinfectant had been left in the shower room. Staff #142 stated he/she would inform the charge nurse who would in turn notify the maintenance department.

Further observation conducted by the inspector revealed that the door handle to an identified shower room remained broken and unlocked. Also the bottle of cleaning disinfectant remained on the wall shelf located inside the shower room.

In an interview, staff #217 indicated he/she would contact maintenance immediately to repair the shower room door lock and would remove the cleaning disinfectant from the shower room.

In an interview, staff #106, confirmed that maintenance had not received any request from the second floor staff regarding the broken door lock or the bottle of cleaning disinfectant being left in the washroom where shower room which was accessible to residents. Staff #106 further stated that he/she would ensure that the shower room door lock would get repaired as soon as possible and that he/she would personally remove the cleaning disinfectant from the shower room. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy related to Missing Clothing and Items was complied with by staff.

During stage one of the Resident Quality Inspection (RQI) resident interviews revealed concerns related to missing clothing and personal items.

Review of the home's policy titled Missing Clothing & Items, policy number VII-C-10.12, revised April 2016, revealed that all missing personal clothing and items that are reported missing will be recorded on the missing clothing & items form and every effort will be made to locate the missing clothing/items.

In an interview, staff #105 stated that on many occasions the laundry receives notification of missing clothing and personal items on scraps of paper. During the interview staff #105 showed the inspector a scrap of paper towel that had written on it a missing item for resident #070.

In an interview, staff#143 stated he/she had written the above mentioned note on the scrap of paper towel for resident #070's missing item. Staff #143 further stated that laundry did not have any missing clothing & items forms so he/she had used the paper towel. He/she stated that was aware of the home's policy and requirement to identify any resident missing clothing or items on the appropriate form.

In an interview, staff #101 stated that staff #143 had not complied with the home's Missing Clothing & Items policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy related to Missing Clothing and Items was complied with by staff, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents at all times.

During the RQI, observations conducted by the inspector at a specified time revealed resident #036 in bed fully dressed lying on top of a sling. The call bell cord was observed dangling from the control panel along the wall and was three feet behind the head of the resident's bed. Resident #036 stated that if he/she had not been able to reach the call bell then would have been able to call for assistance.

In an interview, PSW #219 confirmed that resident #036 was not able to reach the call bell in its current location. PSW #219 further stated that someone might have forgotten to pin it onto resident #036's bed as it should have been after dressing and preparing resident #036 to transfer.

In an interview, DOC #101 confirmed the resident-staff communication and response system should have been easily seen, accessible and used by resident #036 at all times. [s. 17. (1) (a)]

2. During the RQI, observations conducted by the inspector On two identified dates at a specified time revealed resident #082 seated in his/her wheelchair at his/her bedside in apparent discomfort. The inspector asked if resident #082 needed help. Resident #082 stated that he/she had soiled his/her incontinence care product and was in need of a change. The inspector asked if resident #082 had used the call bell and the resident responded "that he/she would have used the call bell if he/she could have reached it". The inspector observed the call bell dangling from the wall onto the floor behind the resident #082's head of the bed. Resident #082 had been about five feet away from the call bell with his/her back to the head of the bed and had not been able to reach the call bell in his/her current position.

In an interview, PSW #154 stated the call bell was supposed to be placed close to the resident after he/she had been transferred from the bed to the wheelchair. The PSW agreed the resident would not be able to use the call bell in its current location. The PSW indicated he/she was not assigned to look after the resident for this shift and did not know why the call bell was not placed near the resident.

In an interview, DOC #101 confirmed that the call bell had not been placed where it was easily seen, accessed and used by resident #082 at all times. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents at all times, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

1. A CIS report was submitted to the MOHLTC related to staff to resident abuse.

Review of the CIS report revealed on a specified date the resident's family member

had met with DOC #101 and reported the following alleged abuse to the home:

-on a specified date PSW #128 handled resident #002 in a rough manner when providing care,
-PSW #128 berated at him/her because the call bell was attached to the handrail and,
-when resident #002 had asked to be toileted at night, PSW #128 told him/her to go in his/her incontinence care product and the incontinence care product would be changed afterwards.

Further review of the CIS report revealed and an interview with DOC #101 confirmed the MOHLTC after-hours number had not been immediately called. The Director was not notified until one day after the home became aware of the alleged abuse. [s. 24. (1)]

2. A CIS report was submitted to the MOHLTC related to staff to resident verbal abuse that had occurred on a specified date, six days after the incident.

Further review of the CIS revealed that resident #007's family member had submitted complaints to management regarding PSW #188 for talking in a "rough manner" and having "no bedside manners" towards resident #007.

In an interview, ADOC #123 confirmed that the MOHLTC had not been notified immediately as per legislative requirements. He/she also confirmed the practice in the home was that when there is a witnessed or alleged abuse reported, the person to whom it was reported to would be responsible for notifying the MOHLTC immediately and for conducting the investigation. [s. 24. (1)]

3. A CIS report report was submitted to the MOHLTC related to staff to resident neglect.

Review of the CIS report revealed that on a specified date resident #003 reported to PSW #121 that PSW #203 had left him/her to sleep in a soiled bed after being incontinent, and the next day. the same PSW did not replace the resident's soiled bed pad. Three day later, the resident's family member submitted a formal complaint to the home about the care his/her mother had received on the two above mentioned incidents.

Further review of the CIS report revealed, and an interview with ADOC #125

confirmed the incident had been reported to the MOHLTC two days after becoming aware of the alleged incident of staff to resident neglect. [s. 24. (1)]

4. A CIS report was submitted to the MOHLTC related to an incident of staff to resident abuse.

Review of the CIS revealed that resident #002 had informed his/her family on a specified date that on the previous day PSW #209 had spoken rudely to him/her. Resident #002's substitute decision maker (SDM) reported the above mentioned incident to ADOC #123.

Further review of the CIS revealed under "actions taken" that the Director had not been immediately notified and that the CIS had been submitted two days later.

In an interview, ADOC #123 confirmed that he/she had not immediately reported the suspicion of abuse and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #16: 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 the resident exhibiting altered skin integrity received a skin assessment by a member of the registered staff upon any return from hospital.

Observations conducted during the stage one process of the resident quality inspection (RQI) revealed resident #035 had altered skin integrity. Further observations revealed two small dressing sites to identified body area and scattered altered skin integrity to identified body areas.

Review of the treatment administration record (TAR) revealed that resident #035 had altered skin integrity that required daily dressing changes and a second area of altered skin integrity that required dressing changes every three days.

Review of the most recent written plan of care revealed resident #035 was at risk for altered skin integrity related to the use of an identified medication.

During the course of this inspection resident #035 was on a medical leave. Upon his/her re-admission to the long term care home (LTCH) a skin assessment had not been completed.

Review of the skin assessments tab under point click care (PCC) revealed that the most recent skin assessment had been completed on an identified date in June 2016.

In an interview, staff #135 stated that skin assessments are to be completed on admission, after any medical leave and leave of absence greater than 24 hours, and with any incidents of altered skin integrity. Staff #135 further stated that a skin assessment had not been completed for resident #035 upon his/her re-admission from a medical leave.l.

In an interview, staff #101 confirmed that a member of the registered staff had not completed a skin assessment for resident #035 upon re-admission from a medical leave. [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 was assessed by a registered dietitian who is a member of the staff of the home.

A CIS report was submitted to the MOHLTC related to a complaint about skin care.

Review of the CIS revealed that resident #013's family member had reported to the Long Term Care Home (LTCH) altered skin integrity of resident #013 that he/she had been experiencing since a medical leave. The CIS further revealed that the family member had continued concerns that the altered skin integrity had become worse following a second medical leave.

Review of the medication administration record (MAR) revealed that identified skin treatments ordered were to be at specified times.

In an interview, staff #114 stated that he/she had not received a referral and had

not been aware that resident #013 had been experiencing ongoing altered skin integrity. Staff #114 further revealed that he/she would not have typically expected a referral for this type of altered skin integrity, however if a resident was experiencing altered skin integrity that was ongoing and persistent, it would have required a referral and an assessment by the RD. Staff #114 stated once he/she had completed an assessment then he/she would add a skin focus to the resident's written plan of care.

Review of the assessment tab under PCC revealed that a referral to the RD had been sent on an identified date in January 2016, related to resident #013's ongoing altered skin integrity.

Review of the most recent written plan of care revealed no focus related to skin care.

In an interview, staff #114 further stated that he/she had not received the above mentioned referral and confirmed that a RD assessment had not been completed for resident #013. [s. 50. (2) (b) (iii)]

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

Observations conducted by the inspector during stage one of the RQI revealed altered skin integrity on resident #035. During this inspection resident #035 had been on a medical leave. Observations conducted upon his/her re-admission from a medical leave revealed altered skin integrity as well as dressings to identified body areas.

Review of the TAR revealed dressing orders to be completed daily had been in place for impaired skin integrity to an identified body area since May 2016, and dressing orders to another identified body area to be completed every three days had been in place since July 2016. Review of the skin assessment tab in PCC revealed the most recent skin assessment completed had been on an identified date in June 2016.

In an interview, staff #135 stated that weekly skin assessments for altered skin integrity are to be completed an identified week day using a clinically appropriate tool located in PCC under the assessment tab. Staff #135 further stated that

resident #035's above mentioned areas of altered skin integrity had not been assessed weekly.

In an interview, staff #101 confirmed that weekly skin assessments had not been completed for resident #035. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
-the resident exhibiting altered skin integrity received a skin assessment by a member of the registered staff upon any return from hospital,
-any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Observation by the inspector revealed that resident #050 had been assisted with feeding by staff #163 while he/she was in a reclined position.

Review of resident #050's most recent written care plan indicated staff should ensure that resident #050 was seated upright during meals and for an identified time period after eating.

In an interview staff #126 stated that resident #050 was positioned in an improper feeding position putting the resident at risk for aspiration.

Observations by the inspector revealed resident #050 had been assisted with feeding by staff #102 while in a reclined position. Resident #050 was observed to be coughing when altered fluids were being fed to him/her by staff #102.

In an interview staff #111 confirmed resident #050 was being assisted with feeding while in an improper position, which placed him/her at risk of aspiration. Staff #111 further confirmed that the proper position for resident #050 while being assisted with feeding was to be seated in an upright position.

In an interview staff #101 confirmed that in this case, the licensee had failed to ensure that staff #102, and #163 had used proper techniques to assist resident #050 with eating, including safe positioning of a resident. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

During this RQI inspection, findings of non-compliance under O. Reg. 79/10, section r. 229, related to the implementation of an infection control and prevention

program in the home resulted in the review of the home's education attendance records for infection control and prevention in 2015.

Review of the home's 2015 infection prevention and control education attendance records revealed that 19 per cent of the staff had not completed the required annual retraining.

In interviews, staff #175, #145 and #177 stated they had not completed the computer component of the required annual training in infection prevention and control for 2015.

In an interview, staff #123 confirmed that 19 per cent of staff had not completed the required annual retraining in infection control and prevention in 2015. [s. 76. (4)]

2. The licensee has failed to ensure that all staff who provide direct care to residents, receives training in behaviour management, at times or at intervals provided for in the regulations.

During this RQI inspection, findings of non-compliance related to responsive behaviours resulted in the review of home's education attendance records for 2015.

Review of the home's 2015 education attendance records revealed that 31 per cent of staff had not received training in behaviour management.

In interviews, staff #175 and #177 stated they had not completed behaviour management training in 2015.

In an interview staff #103 stated that in previous years behaviour management training had not been consistent and that moving forward the home had developed a plan to ensure all direct care staff received training in behaviour management annually.

In an interview staff #123 confirmed that 31 per cent of staff had not received training in behaviour management in 2015. [s. 76. (7) 3.]

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 persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection including, infection prevention and control at times or at intervals provided for in the regulations, and,
- to ensure that all staff who provide direct care to residents, receive training in behaviour management, at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents.

Resident #063 expressed concerns to the inspector related to supplies not being available during the provision of care.

Review of the inventory provided by staff #106 revealed the following supplies on hand in the home:

Amount of towels	Required amount	Actual amount
Bath	1196	500
Hand	2093	500
Face cloth	2093	800
Peri-care cloth	2392	800

In an interview, staff #139 stated that staff use one end of the towel to wash the resident and the other end to dry the resident.

In an interview, staff #105 confirmed the home had been lacking supplies of towels. Instead of sending 60 towels of each type to each floor for each shift, only 30-40 of each type of towels had been sent. This concern was brought to the attention of staff #106.

Interviews with staff #101 and #106 confirmed the home's supplies had been insufficient to meet residents' needs, and that additional supplies (towels) had been ordered. [s. 89. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances are kept inaccessible to residents at all times.

Observation conducted by the inspector in an identified shower room revealed that the door handle and key pad had been broken and could not be locked. A bottle of cleaning disinfectant was noted on a wall shelf located inside the shower room.

In an interview, staff#142 stated the door key had been broken for a while and maintenance had been made aware of the issue. Staff #142 further stated he/she had not been aware why the cleaning disinfectant was left in the shower room. Staff #142 also stated he/she would inform the charge nurse who would in turn notify the maintenance department.

Further observations by the inspector of the identified shower room revealed the door handle remained broken and that the bottle of cleaning disinfectant remained inside the shower room.

In an interview, staff #217 stated he/she would contact maintenance immediately to repair the door lock and would remove the tub disinfectant from the shower room.

In an interview, staff #106 confirmed that maintenance had not received any request from the second floor staff regarding the broken door lock and that a bottle of
cleaning disinfectant had been left in the washroom which was accessible to residents. Staff #106 stated that he/she would ensure that the door lock got repaired as soon as possible and that he/she would personally remove the tub disinfectant from the shower room. [s. 91.]

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 hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
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. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident 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. 104 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a report was made in writing to the Director setting out actions taken in response to the incident, including the outcome or current status of the individual or individuals who were involved in the incident.

1. A CIS report was submitted to the MOHLTC related to staff to resident abuse.

The CIS revealed that in an interview, resident #006 stated he/she had requested staff#137 to wash him/her properly using a basin, with warm, soapy water and a towel. Staff #137 told the resident that the basin was in the washroom and he/she did not have the time to get it. Staff #137 then got a damp towel, wrung it out and wiped resident #006 with it. He/she then asked the resident to turn around and used the same dirty towel to wipe him/her again. Resident #006 also reported that staff #137 had provided improper morning care on other occasions and that he/she had apologized, however resident #006 was pleased that staff #137 no longer provided care to him/her.

Review of the CIS report and interview with DOC #101 confirmed that the CIS report had not been amended to include the outcome of the investigation, additional strategies and/or interventions planned to prevent recurrence. [s. 104. (1) 3.]

2. A CIS report was submitted to the MOHLTC related to an incident of staff to resident verbal abuse.

The CIS revealed that resident #019 had complained to staff #126 that staff #207 had changed his/her dressing time from evening shift to day shift. The CIS revealed that staff #207 had decided the dressing was better suited to day shift as resident #019 was bathed on days. Further review of the CIS revealed, under the general notes section, a request from the MOHLTC for the CIS to be amended to include the outcome of the home's internal investigation.

In an interview, staff #101 revealed that the home's internal investigation had been completed and confirmed that the CIS had not been updated to include the outcome of the home's internal investigation as requested. [s. 104. (1) 3.]

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 report was made in writing to the Director setting out actions taken in response to the incident, including the outcome or current status of the individual or individuals who were involved in the incident, to be implemented voluntarily.

WN #22: 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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that training related to continence care and bowel management was provided to all staff who provide direct care to residents on either an annual basis, or based on the staff's assessed training needs.

During this RQI inspection, findings of non-compliance related to continence care and bowel management resulted in a review of the home's education attendance records for 2015.

Review of home's to continence care and bowel management training record for 2015, and interview with staff#123, confirmed that 34 per cent of direct care staff had not received retraining on continence care and bowel management in 2015. [s. 221. (1) 3.]

2. The licensee has failed to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually.

During this RQI inspection, findings of non-compliance related to abuse recognition and prevention resulted in a review of the home's education attendance records for 2015.

Review of the home's education records for 2015 related to Abuse Recognition and Prevention revealed that 16 per cent of direct care staff had not completed annual retraining.

In interviews, with staff #175, #177 and #178 they stated they had not completed annual retraining in abuse recognition and prevention.

In an interview, staff #123 confirmed that 16 per cent of direct care staff had not completed annual retraining in abuse recognition and prevention during 2015. [s. 221. (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:
- training related to continence care and bowel management was provided to all staff who provide direct care to residents on either an annual basis, or based on the staff's assessed training needs, and
- all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually, to be implemented voluntarily.

WN #23: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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 a written record of the annual Infection Prevention and Control program evaluation was kept that includes the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented.

During this RQI inspection, non-compliances related to O. Reg. 79/10 section 229, resulted in the review of the home's annual infection prevention and control program evaluation.

Review of the home's annual infection prevention and control program evaluation document indicated a review period from November 2015 to June 2016. The document indicated four nursing management staff had participated in the

evaluation. Goals and objectives for the period under review were identified as:

1) reduce number of outbreaks,
2) infection control surveillance record, and
3) reduce number of Urinary Tract Infection (UTI) cases. Date of report was noted absent on the form.

The date of the completion of the identified action items were also not on the form.

In an interview, staff #101 stated the document had been the most current evaluation for the infection prevention and control program. Staff #101 later presented another program evaluation dated October 2015, for the period between October 2014 to October 2015. Goals and areas for improvement had been identified in the document however the completion dates for the identified action items had not been recorded.

In an interview, staff #101 confirmed that the written record of the annual evaluation of the infection prevention and control program had not included the dates when changes had been implemented. [s. 229. (2) (e)]

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

Observations conducted by the inspector revealed staff #132 mopping four identified resident rooms without changing the water or the mop head. Further observation revealed that the resident in one room was on precautions related to an infection.

Review of the home's infection prevention and conttol program policy titled: "Isolation Cleaning Procedures" , policy number IX-J-10.10 with a revised date of April 2016, directed staff to place mop head and rag into a plastic bag, empty the mop bucket and replace cleaning solution before going on to clean the floors in another resident room.

Interviews with staff #130, #131 and #132 confirmed the above resident rooms had been cleaned with the same solution and mop head.

In an interview, staff #136 confirmed that staff #132 had cleaned all of the above mentioned rooms including the room with isolation precautions without changing

the solution and mop head and therefore had not participated in the implementation of the infection prevention and control program. [s. 229. (4)]

3. Observations conducted by the inspector during stage one of the RQI revealed an unlabeled styrofoam cup located in the shared bathroom which contained the following unlabeled items:
three toothbrushes,
-a comb,and
- a bar of soap.

Further observations conducted by the inspector revealed that in the shared bathroom there remained three unlabeled toothbrushes in a styrofoam cup.

In an interview staff #121 revealed that these toothbrushes belonged to three different residents, and confirmed that these resident personal care items should have been labeled and stored separately to prevent the spread of infectious disease. Staff #121 further stated that night shift staff members have been responsible for the labeling of all resident personal items.

Observations conducted by the inspector during stage one of the RQI revealed in a shared bathroom an unlabeled ceramic coffee mug that contained several toothbrushes, razors, a comb, and hair brush that were all unlabeled.

Further observations conducted by the inspector of the shared bathroom revealed that the ceramic mug containing resident personal care items remained unlabeled.

In an interview, staff #110 stated that the above mentioned unlabeled resident personal care items all belonged to one resident in the room as the other residents used dentures.

In an interview, staff #135 confirmed that the mug containing resident personal care items should have been labeled to prevent the transmission of infection.

Record review of Night Shift PSW Cleaning schedule checklist revealed that all resident personal care items are expected to be labeled weekly on Tuesday nights.

In an interview, staff #135 confirmed that PSW staff have been responsible for the labeling of resident personal care items, which is included in the infection prevention and control program and as a result had failed to participate in the

infection prevention and control program. [s. 229. (4)]

4. Observation conducted by the inspector revealed the following unlabeled items on the counter top in a shared bathroom.

-five used toothbrushes,
-an open razor inside a mug,
-three denture cups,
-one used hair brush, and
-one unlabeled urine measuring receptacle was noted on top of the toilet tank.

In an interview, staff #142 stated that the residents' personal care items should have been labeled. Staff #142 further stated that he/she would the above mentioned resident personal care items were labeled.

In an interview, staff #101 confirmed that PSW staff have been responsible for the labeling of resident personal care items, which is included in the infection prevention and control program and as a result had failed to participate in the infection prevention and control program. [s. 229. (4)]

5. Observations conducted by the inspecto revealed the wall hand sanitizer bottle to be empty in an identified room.The inspector also attempted to use it and found it was not working.

In an interview, staff #143 stated that the hand sanitizer bottle had been empty and he/she would inform housekeeping staff. Staff #143 returned and informed the inspector that he/she had reported to housekeeping staff on the second floor who would in turn report to the housekeeping supervisor to follow up.

In an interviews, staff #136 and #101 confirmed that the housekeeping staff on specific home areas were responsible to refill the hand sanitizer containers when empty. [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:
-a written record of the annual Infection Prevention and Control program evaluation was kept that includes the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented, and
-all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that a registered dietitian who is a member of the staff of the home completed a nutritional assessment for all residents whenever there is a significant change in a resident's health condition.

1. A census record review conducted during stage one of the RQI revealed that resident #030 had been on a medical leave for a specified amount of time.

Review of resident #030's progress notes revealed that a dietary referral had been completed by staff #146 for re-admission related to a change in condition. The dietary referral had been addressed by staff #118 who stated the RD would follow-up to assess.

In an interview, staff #114 revealed that a referral had been received and had likely been responded to by one of the dietary supervisors. Staff #114 stated that hat he/she had not completed an assessment for resident #030 until 33 days later. Staff #114 further stated that the expectation would have been to assess the resident as soon as possible following a significant change, and in this case the assessment had not happened.

In an interview, staff #101 stated that resident #030 had returned from a medical leave with a significant change in condition. Staff #101 confirmed that it is the expectation of the home for the RD to complete an assessment of any resident returning from a medical leave with a significant change in condition. Staff #101 confirmed that in this case the licensee had failed to ensure that a RD who is a member of the staff of the home completed a nutritional assessment for all residents whenever there is a significant change in a resident's health condition. [s. 26. (4) (a),s. 26. (4) (b)]

2. Observations conducted during stage one of the RQI revealed resident #035 had altered skin integrity that required further inspection. During the inspection resident #035 had been on a medical leave for treatment of underlying health conditions.

Review of progress notes for resident #035 revealed while on a medical leavel he/she had been admitted to the palliative care unit. Progress notes further revealed that resident #035's next of kin would be in to change the advanced directive upon re-admission to the LTCH.

Review of the assessment tab in PCC revealed a referral to the registered dietitian (RD) had been initiated after re-admission from the medical leave but had not been completed and therefore not sent to the RD.

In an interview, staff #135 revealed that the assessment titled "referral V8" in PCC under the assessment tab is the referral completed for RD referrals on new admissions, re-admissions from medical leaves, for weight changes, for any changes in dietary intake and for any significant changes in a resident's health condition. Staff #135 further revealed the above mentioned referral must be completed and signed off to generate a referral within the PCC program. Staff #135 confirmed that the referral had not been signed off.

In an interview, staff #185 he/she had not received a referral for resident #035. Further review of staff #185's referral list revealed a referral for resident #035 had been initiated upon re-admission from the medical leave and signed off four days later. Staff #185 stated that he/she had missed this referral as it had been signed off four days after being initiated and as a result the referral would show on the RD's electronic list on the initiated date only. Staff #185 further stated that he/she would not typically go back to look for missed referrals.

In an interview staff #185 confirmed that a nutritional assessment for resident #035 had not been completed when there had been a significant change in his/her health condition. [s. 26. (4) (a),s. 26. (4) (b)]

WN #25: The Licensee has failed to comply with LTCHA, 2007, 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 a response in writing was made within 10 days of receiving Family Council advice related to concerns or recommendations.

An interview with staff #129 revealed concerns that had been raised at the Family Council meetings were responded to by the home at the next Family Council meetings a month later. One of the concerns raised at a meeting in May 2016, included a request to have telephones available in the home areas for residents to use in a more private and welcoming setting. Staff #103 had responded to the Family Council in a written letter dated 34 days later.

In an interview, staff #129 stated when there had been a concern raised that he/she would complete the concern form referring the concerns to the appropriate department head at the daily management meeting. Concerns were then investigated by the respective departments and the responses were brought forward to the Family Council at the next month's meeting. Staff #129 indicated a list of concerns from before being hired that had been given to him/her when he/she had started in February 2016. Staff #103 had responded to these concerns in writing and staff #129 presented the responses at the May 2016 meeting.

In an interview, staff #103 confirmed that responses in writing had not been made within 10 days of receiving Family Council advice related to concerns or recommendations. [s. 60. (2)]

WN #26: The Licensee has failed to comply with LTCHA, 2007, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks are conducted prior to hiring the staff member and/or accepted volunteer who is 18 years of age or older.

O. Reg. 79/10, s. 215 (1) (b) states a criminal reference check is required before a licensee hires a staff or accepts a volunteer as set out in subsection 75 (2) of the Act, and that it was conducted within six months before a staff member hired by the licensee.

Findings of non-compliance related to O. Reg. 79/10, s. 19, Prevention of Abuse in this RQI inspection resulted in the review of staff personnel files.

Record review of staff personnel files revealed staff #186 had been hired in July 2016, prior to a criminal reference check and vulnerability screening having been conducted.

In an interview, staff #119 stated that staff #186 had orientation on two specified dates 2016, where he/she had shadowed staff #186.

In an interview, staff #146 stated he/she had participated in an orientation with staff #186 where residents had been introduced to him/her and where he/she had an opportunity to conduct a program under staff #146's supervision.

In an interview, staff #186 further stated that he/she had not completed a criminal reference check and vulnerability screening prior to being hired.

In an interview, staff #119 confirmed that a criminal reference check and vulnerability screening for staff #186 had not been completed until 21 days after staff #186's date of hire. [s. 75. (2)]

2. O. Reg. 79/10, s. 215. (3) states the criminal reference check must include a vulnerable sector screen to determine the person’s suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

Record review of staff personnel file for staff #188 revealed that a Criminal Reference Search had been submitted on a specified date in October 2015. This search had been conducted by third party and the form had required staff #188 to

visit his/her local police service for an entirely new criminal record search that included fingerprinting. A subsequent more in-depth search was conducted on a specified date in October 2015, which had not included a vulnerable sector check.

In an interview, staff #103 confirmed that based on the records contained in the staff personnel file for staff #188 a vulnerable sector screen had not been completed prior to the staff member performing his/her duties. Staff #103 confirmed that the licensee failed to ensure that criminal reference checks were conducted prior to hiring the staff member. [s. 75. (2)]

WN #27: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after resident #032 sustained an injury that resulted in a significant change in resident #032's health condition and for which resulted in a transfer to hospital.

A CIS report was submitted to the MOHLTC related to resident #032 experiencing a suspected injury to an identified body area.

Review of resident #032's progress notes revealed that a physician in the home had completed an assessment ordering an x-ray of an identified body area. The x-ray revealed an underlying medical health condition and injury. Resident #032 was sent to hospital for further assessment and returned later the same day following treatment.

In an interview, staff #138 stated that reporting requirements had been unclear to him/her and confirmed that the above mentioned CIS had been submitted four days after the diagnosis of an underlying injury to an identified body area. [s. 107. (3)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act, includes the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act.

In an interview, a complainant stated to an inspector that he/she had mailed a complaint to the Director and that it had been returned to him/her with a notification of an incorrect name and address on the envelope.

Observations by the inspector revealed that the ActionLine posters on the main floor and one posted on an identified resident home area contained an incorrect mailing address and incorrect name of the Director to whom a mandatory report shall be made under section 24 of the Act.

In an interview, staff #103 had not been not aware that the name and address of the Director had been inaccurate on the ActionLine posters posted in the home. [s. 225. (1) 4.]

Issued on this 6 day of February 2017 (A2)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JOANNE ZAHUR (589) - (A2)

Inspection No. / No de l'inspection : 2016_353589_0016 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 023257-16 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 06, 2017;(A2)

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 : Midland Gardens Care Community
130 MIDLAND AVENUE, SCARBOROUGH, ON, M1N-4B2

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

Ministère 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 Administrator / Nom de l'administratrice ou de l'administrateur : Sara Rooney

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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 : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Order / Ordre :

The licensee shall ensure the home's Hot Weather - Management of Risk and Heat Contingency Protocols are implemented as per evidence-based practice related to Humidex values.

Grounds / Motifs :

1. The licensee shall ensure the home's Hot Weather - Management of Risk and Heat Contingency Protocols are implemented when a Humidex value is between 30 and 39.

The licensee has failed to ensure that the written hot weather related illness prevention and management plan for the home that meets the needs of the residents, was implemented to address the adverse effects on residents related to heat.

According to evidence-based practice titled "The Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care, July 2012", developed by the Ministry of Health and Long Term Care, routine checks to assess indoor air temperatures and Humidex levels at varying times throughout the day should be implemented. The guidelines include direction to monitor outdoor air temperatures and Humidex levels to determine when indoor values needed to be evaluated. Once a Humidex value is between 30 and 39, which is a zone where most individuals would feel some discomfort, staff would need to be informed to enhance their monitoring of residents who were assessed at high to moderate heat risk. In some cases, monitoring of residents with specific health conditions would need to be monitored at a Humidex as low as 32.

Review of home's most recent policy titled Hot Weather-Management of Risk #VII-G-10.10 and Heat Contingency Protocols #VII-G-10.10 (a), stated that in the event of heat alert or heat wave, staff are required to close all curtained areas and windows during the day and shut off the lights that are not required to minimize heat. Maintenance is required to record indoor temperature and humidity percentage from various locations within the building daily and inform all departments of the heat contingency protocols to be implemented. The policy also required staff to receive annual education / information on prevention and management of heat related illness and hot weather plans.

Review of the home's Heat Contingency Protocols policy revealed three threshold levels that include Summer Practice, Intervention Alert, and Emergency Alert. Each threshold level had specific interventions for residents identified as being as high heat risk.

Interventions included that staff are required to close all curtained areas and windows during the day, shut off the lights that are not required to minimize heat and move residents to designated cooling areas.

Review of the air temperature log during the resident quality inspection (RQI) revealed the following air temperatures and humidity levels:
-at an identified nursing station was recorded at 30.3 degree Celcius and humidity at 64.4,
-at an identified nursing station was recorded at 30.3 degrees Celcius and humidity at 67.2.
The emergency threshold level is identified as an air temperature that is greater than

29 degrees Celcius.
Based on the home's Heat Contingency Protocols policy an emergency alert should have been in place at time of the inspection.

Interview with the staff #123 revealed that designated cooling areas in the home had been identified as the dining rooms located on each resident home area.

Interview with the staff #106 confirmed an emergency alert had not been communicated to staff in the home.

An observation by the inspector revealed resident #061 positioned in the common area by the nursing station. Resident #061 required supplemental breathing equipment and was complaining of feeling very hot. Resident #061's heat assessment score assessed them to be at risk.

An observation by the inspector revealed multiple residents positioned in the common area by the nursing station and in the east corridor. Four staff were observed seated in the designated cooling area. Further observations revealed resident #060 positioned in the common area by the nursing station with supplemental breathing equipment in place. Resident #060 was restless, sweating profusely and had dry lips. Staff serving nourishment passed by without offering any nourishment to resident #060. The inspector interviewed resident #060 with staff #121 as a translator. The resident stated that he/she was hot and thirsty. Inspector #502 requested that staff #121 provide fluid to resident #060. Further observations revealed that random resident rooms had open windows, curtains not drawn closed and a corridor window had a broken closing latch preventing it from closing properly.

Interviews with staff #122 and staff #120, #121 and #124 revealed that they were not aware of the heat related action plan that should be in place to address the heat condition. She/he revealed that the emergency alert had not been communicated today. The inspector instructed staff to move residents into the dining room. Staff #122 revealed to the inspector that the air conditioning (AC) unit in the cooling area had not been working and the area was hot. Inspector #502 observed that the AC unit was working and brought the concern to staff #123's attention. He/she immediately informed all nursing staff to stop whatever they were doing and move the residents into the cooling area immediately. [s. 20. (1)]

(589)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 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

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

Aug 12, 2016

Order # /
Ordre no : 001

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

Linked to Existing Order /
Lien vers ordre existant: 2016_226192_0013, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 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

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

The plan will include, at a minimum, the following elements:

-Develop a cleaning schedule for the home, furnishings and equipment and,
-Develop a maintenance schedule to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Please submit the plan to Joanne.Zahur@ontario.ca no later than January 20, 2017.

Grounds / Motifs :

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

Compliance order CO#001 issued in April 2016, related to accommodations services-maintenance required follow-up during this RQI inspection.The order directed the home to ensure that all equipment required to provide resident care, shower rooms, walls, baseboards and windows in the home are kept clean and sanitary and that monitoring processes are developed to maintain and monitor the cleanliness of all of these items. The home was to have been in compliance by a specific date in July 2016.

On multiple occasions during the RQI, the inspector made several observations and interviews with staff related to the cleanliness of the home.

An observation by the inspector revealed a dirty toilet bowl on the outside of the bowl near the bottom of a shared bathroom.

In an interview, staff #220 stated he/she had not been aware that the toilet bowl had been dirty and would notify housekeeping staff to clean it.

In an interview, staff #136 confirmed the toilet bowl was not cleaned and stated that the housekeeping aide should have cleaned the washroom including toilet bowl. [s. 15. (2) (a)] (512)

2. Observations during the RQI revealed the base of a mechanical lift apparatus was observed to be unclean.

In interviews, staff #142 and #217 confirmed the mechanical lift apparatus had not been cleaned and the staff #142 stated that it should have been cleaned at the end of each use.

In an interview, staff #101 stated it is the home's expectation that PSW staff clean the mechanical lift apparatus to ensure it is kept clean and sanitary. [s. 15. (2) (a)] (512)

3. Observations by the inspector revealed a window in the residents' library soiled with black debris, dust and dead insects between the screen and window pane and also in the main floor north and south stairwell which was accessible to residents.

In an interview, staff #106 confirmed the above observations and stated that the home had no working or preventative cleaning schedule in place for the interior of the windows in the common areas of the home accessible to residents. [s. 15. (2) (a)] (512)

4. An observation conducted by the inspector revealed the top edge of the handwashing sink in the kitchen was covered with black and brown debris.

Staff #118 had been present during this observation and stated that he/she would look into having the sink cleaned.

Further observations conducted in the kitchen during the RQI recvealed the hand washing sink in the same unclean condition.

In an interview, staff #103 confirmed the home's furnishings and equipment had not been kept clean and sanitary. [s. 15. (2) (a)]
(512)

5. The licensee has failed to ensure that there is cleaning schedule for all the equipment related to the food production system.

Observations in the kitchen were conducted as a follow-up to compliance order #001 issued in April 2016, under inspection number 2016_226192_0013.

Observations conducted by the inspector and staff #118 revealed the following:

-ceilings and walls of the walk-in fridge and freezers were unclean,
-walls that did not have boxes and crates with food items in front were unclean, and
-a panel inside the ice machine was also unclean.

In an interview, staff #118 agreed that the ice making machine needed to be cleaned.

Further observations of the kitchen conducted by inspectors #501 and #512 revealed the panel of the ice machine had been cleaned, however it still remained visibly unclean.

In an interview, staff #118 stated that the walk-in fridge and freezers had been last cleaned by a newly hired cook had been brought in to do the cleaning. The cook had swept and mopped the floors of the fridge and freezers however the ceilings and walls had not been cleaned.

Staff #118 had been unable to provide a cleaning schedule to show that the ice making machine had been cleaned prior to this inspection.

In an interview, staff #225 stated the home had no cleaning schedules for the walk-in fridge, the walk-in freezers, and the ice machines. The home is currently working to set up these cleaning schedules.

In an interview, staff #103 confirmed that there had been no cleaning schedules for equipment related to the food production system. [s. 15. (2) (a)]
(512)

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

Housekeeping
• Dirty washroom toilet in an identified resident bathroom,
• Dirty table top in an identified resident bathroom, and
• Dirty base of sit/stand lift in an identified tub room
• Windows dirty with debris and dust – two hallway windows on doors to the outside, a windows in the residents' library soiled with black debris, dust and dead insects in-between the window and screen.

Dietary Services
• Equipment not sanitary – walk in freezers x2 and fridge x 1, ice machine with a mould-like substance on the top surface inside the machine,

Interviews with staff and ED confirmed the home's furnishings and equipment are not kept clean and sanitary. (512)

7. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The MOHLTC ActionLine received a complaint related to the lack of maintenance in the home. The complainant reported that the tap in the dining room had fallen off in his/her hands when he/she had tried to turn the tap on.

During the RQI the inspector attempted to turn on the tap by a hand-washing sink beside the servery in a specified dining room. The inspector noted it had not remained totally secure to the actual faucet attachment. It was also observed that the tap remained operational as evidenced by running water out of the tap.

In an interview, staff #218 confirmed that he/she had washed his/her hands numerous times at this tap and was not aware that it was not secured to the base of the faucet.

In an interview, staff #106 stated that he/she had not received a request for the broken tap however he/she would look into it.

In an interview, staff #103 confirmed that the tap in the fifth floor dining room had not been maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

(512)

8. On multiple occasions during the RQI, inspector #502 and inspector #512 observed in an identified room a wall in disrepair with insulation material visible.

In an interview, resident #086 stated the wall had been in disrepair for a few months and he/she had reported this to the maintenance staff some time ago.

In an interview, staff #216 stated he/she had not been aware of the holes in the wall and had not received any report from PSW staff.

In an interview, staff #106 and staff #103 confirmed that the wall in an identified room had not been maintained in good state of repair. [s. 15. (2) (c)]
(512)

9. Observation conducted by the inspector during the RQI on two identified dates revealed the following in a specified room:

-chipped paint and multiple scratch marks at bottom of wall,
-two holes, each sized two inches in diameter in the corner and one near the baseboard on the wall,
-a light diffuser panel on the ceiling noted to have three blots of debris resembling dead insects in it,
-the faucet in the washroom running continuously with hot water which could not be turned off when tested and,
-a hole behind the toilet seat sized two inches in diameter, two ceiling tiles with water marks, dry wall peeled off in an adjacent area, and multiple scratch marks in the washroom.

In an interview, staff #222 stated the faucet had been leaking two weeks ago and had been repaired by maintenance. Staff #222 further stated that he/she had not been aware the faucet had been leaking for the past four days.

In interviews, staff #106 and staff #103 confirmed the walls, faucet, ceiling tiles and light diffuser panel had not been maintained in a good state of repair. [s. 15. (2) (c)]

(512)

10. The inspector observed the following in a specified room:

-wall paper peeled off three quarters of the length of the door height exposing dry wall underneath at the door way, and
-staples noted on wall paper which appeared to indicate previous attempts to fasten peeled off wallpaper to the wall.

In an interview, staff #100 stated that he/she had not been aware of the above mentioned areas of disrepair.

In an interview, staff #106 confirmed that the request for repairs had been received and that wall paper by the door frame had been in need of repair.

In an interview staff #103 confirmed that the above mentioned areas of disrepair had not been maintained in a good state of repair. [s. 15. (2) (c)]
(512)

11. Observations conducted by the inspector with staff #118 revealed the handwashing sink by the kitchen door had been covered with black and brown debris along the top edge, and that part of the caulking had been missing.

In an interview, staff #118 stated that he/she will look into having the sink cleaned and would notify the maintenance department to replace the caulking.

Further observations by the inspector revealed the hand washing sink to be in the same condition as described above.

In an interview, staff #106 confirmed that he/she had not received a maintenance request for the hand washing sink in the kitchen.

The severity is potential for actual harm related to the ongoing uncleanliness of the home, and the scope is a pattern as numerous areas of the home were observed to be in a state of uncleanliness. Compliance history identified a compliance order had been served under O. Reg. 79/10 s. 15., in April 2016, with a compliance date in July 2016. Due to ongoing non-compliance with O. Reg. 79/10 s. 15. a compliance order is warranted. [s. 15. (2) (c)]
(512)

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

Mar 10, 2017

Pursuant to / Aux termes de :

LTCHA, 2007, s. 65. A licensee of a long-term care home,
(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;
(b) shall not prevent a member of the Residents' Council or Family Council from entering the long-term care home to attend a meeting of the Council or to perform any functions as a member of the Council and shall not otherwise hinder, obstruct or interfere with such a member carrying out those functions;
(c) shall not prevent a Residents' Council assistant or a Family Council assistant from entering the long-term care home to carry out his or her duties or otherwise hinder, obstruct or interfere with such an assistant carrying out those duties; and
(d) shall ensure that no staff member, including the Administrator or other person involved in the management or operation of the home, does anything that the licensee is forbidden to do under clauses (a) to (c). 2007, c. 8, s. 65.

Order / Ordre :

The licensee shall ensure that no staff member, including the Administrator or other person involved in the management or operation of the home interferes with the operation of the Residents' Council.

Grounds / Motifs :

1. The licensee has failed to ensure that the operation of the Residents' Council was not interfered with.

Record review of the Residents' Council meeting minutes for a four month period in 2016, revealed an election had been held on August 2016, to replace the former President of the Residents' Council.

Interviews were conducted with resident #080 on two identified dates. Resident #080 told the inspector that an election had been held to replace the former President of the Residents' Council. Resident #080 further stated that four residents had been voted in, including him/herself and resident #081, who had been the Vice President

previously. Resident #080 stated he/she had been told by staff #119 that he/she had received the most votes at the Residents' Council election and believed that he/she would be designated as the President of the Residents' Council.

In an interview, resident #080 stated that he/she had been the Vice President (VP) of the Residents' Council for the last five years and believed that he/she would be the VP again for this new Residents' Council.

In an interview, staff #119 the Residents' Council assistant stated the Residents' Council had met after the election, and that residents had expressed an unwillingness to take on the responsibility of the designated roles including President and VP. Staff #119 further stated a representative from the Ontario Association of Residents' Council (OARC) had been booked to speak at a Residents' Council meeting about a new leadership model where all residents on the Council would work together instead of having designated roles. Staff #119 stated he/she had explained the new leadership model to the residents on the Council and they all had agreed to it.

Review of the Residents' Council meeting minutes for two months had not revealed any presentation made by OARC had included discussion on the new leadership model. The inspector requested the Residents' Council meeting minutes for a specific date to review. Review of the Residents' Council meeting minutes provided revealed in the "other", section, an entry recorded as: Election Outcome: Newly elected Resident Council Leadership team had been introduced as resident #081, resident #080 and two other co-residents. The New Leadership model had been explained as the elected team working together to meet the objectives of the Resident Council Executive, with no designated role (i.e. President, V. President etc.)

In interviews, resident #080 and resident #081 stated they could not recall any new leadership model having been discussed.

In an interview, staff #226 stated he/she had received a request from staff #119 to present the new leadership model to the home's Residents' Council. Staff #119 had expressed that the home's Residents' Council had been struggling as it had lost a few members recently. Staff #226 had not been aware that anyone on the Residents' Council had objected to taking on the individual officer roles within a Residents' Council nor did any residents voice any objections during the presentation.

In an interview, resident #080 further stated that at past meetings, the three co-residents on the Residents' Council had only expressed an unwillingness to take over the responsibility of looking after the Residents' Council funds. Resident #080 further stated he/she had been willing to take over the financial responsibility as well.

In interviews residents #081 and #080 stated that staff #119 had met with the Residents' Council and resident #080 indicated the Council had been told that, "There is going to be no real structure any more. There is not going to be a president and a vice president. We were told that this direction had originated from the central Residents' Council Committee which oversees Residents' Councils in all the homes." Resident #081 indicated the reason for this new structure had been, "because we are short, we only have four on the council. We need to have five in the Residents' Council to have a president and vice president."

In interviews, the staff #119 and staff #103 stated there had been some miscommunication between the residents and the home. Staff #119 stated that maybe because he/she had only been on the job since the beginning of the year, the residents had misunderstood him/her.

In interviews, staff #119 and staff #103 confirmed that the operation of the Residents' Council had been interfered with by changing the structure of the Residents' Council without the involvement of the members of the Residents' Council after the Residents' Council held an election and established new executive.

The severity is minimum risk to potential for harm, related to confirmed licensee interference with the structure of the Residents' Council and residents' emotional response to the proposed change in the structure of the Residents' Council. The scope is widespread as it affects all residents. There is no previous compliance history related to s. 65. Due to the confirmed licensee interference with the structure of the Residents' Council, a compliance order is warranted.. [s. 65. (a)] (512)

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

Feb 13, 2017

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

Ministère 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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_324567_0016, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents with transfers.

The plan will include, at minimum the following elements:
-Education for all direct care staff, including:
*the different types of transfers methods that can be used with residents,
*the manner in which identified transfer methods are to used to ensure resident safety,
-A system to randomly audit resident transfer practices to ensure:
*transfer methods in place have been guided by residents' individual care planned needs.

Please submit the plan to Joanne.Zahur@ontario.ca no later that January 20, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The home received a compliance order that directed the home to ensure that staff use safe transferring and positioning devices or techniques when assisting residents who require assistance with transfers. The home was to be in compliance by April 2016.

The MOHLTC ActionLine received a complaint related to resident #027 sustaining an injury that the complainant believed had occurred in the home.

Review of resident #027's health record revealed that he/she was not able to be interviewed as he/she was no longer able to express him/herself.

Review of an individualized resident assessment revealed resident #027 had been able to maintain position and trunk control. Review of resident #027's plan of care which was after the alleged above mentioned incident revealed resident #027 now required two staff to provide extensive assistance for all mobility and positioning needs.

During the RQI, the inspector observed staff #162 transferring resident #027 without any assistance.

In an interview, staff #162 stated he/she would ask another staff member to assist with mobility and positioning needs of resident #027 only when required.

In an interview, staff #142 confirmed that staff had not used safe transferring and positioning devices or techniques when assisting resident #027.

The scope of this finding is isolated to one resident, the severity is a potential for harm. The previous compliance history revealed a compliance order had been left with a compliance date in April 2016. As a result of this ongoing non-compliance with O. Reg. 79/10, s. 36, a compliance order is warranted. [s. 36.]
(502)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Feb 24, 2017

Order # /
Ordre no : 004

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

Linked to Existing Order /
Lien vers ordre existant: 2016_226192_0014, CO #002;

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 outlining how the home will ensure the following areas are addressed:

-Each resident who is incontinent receives an assessment that includes the identification of causal factors, patterns, method of transfer and, type of incontinence using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.
-Each resident who is incontinent has an individualized toileting plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on their assessment,
-Each resident who is unable to toilet independently some or all of the time receives the assistance from staff to manage and maintain continence,
-A monitoring system to ensure that there is a sufficient supply of incontinence care products that are accessible to residents and staff for all required changes and,
-Education to all direct care staff regarding:
*how to use incontinent products properly,
*not to use incontinent products as an alternative to providing toileting assistance, and
-A monitoring system to ensure staff are using the incontinence care products as specified by the manufacturer.

Please submit the plan to Joanne.Zahur@ontario.ca no later than January 20, 2017.

Grounds / Motifs :

1. The licensee 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.

During an interview, resident #066 stated that after a specified amount of time he/she could feel that the incontinence care product was soiled and he/she had been uncomfortable. Resident #066 further stated that his/her incontinence care product was only changed once per shift, and that during the night shift he/she had not been changed or provided proper hygiene by staff #201. Resident #006 further stated he/she is usually told him/her to wait for the next shift due to lack of supplies by staff #201.

Review of resident #066's health record revealed that continence assessments had not been completed on admission nor up to the time of this inspection, using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

In an interview, staff #101 stated all residents should be assessed on admission, annually and when there has been a change in condition. He/she stated they were unaware as to why the resident had not been assessed using the above identified tool. [s. 51. (2) (a)] (502)

2. The home had received a compliance order which directed the home to ensure that resident #004 and every other resident who had been assessed to require mechanical transferring apparatus' also have their continence reassessed using an appropriate assessment instrument. The home was to be in compliance by June 2016.

Review of the home's Transfers Method – Mechanical Lift assessment with a completion of date June 2016, conducted by staff #128 revealed resident #004 required a mechanical transferring apparatus for transfers from one surface to another.

Throughout the Resident Quality Inspection (RQI) resident #004 was only observed seated in his/her own chair.

Review of the resident's #004's Continence/Bowel Assessment revealed resident #004 had been last assessed ion a specified date in April 2014, and had been continent of bladder and bowel at the time of this assessment.

Review of resident #004's RAI-MDS assessment dated June 2016, revealed resident #004 now was continent of bowel and incontinent of bladder. A reassessment of resident #004 had not been identified.

In an interview, resident #004 stated it usually takes multiple staff members to transfer him/her using a mechanical transferring apparatus onto a toileting aid twice daily at two specified times in the day.

In an interview, RN #161 stated that a clinically appropriate assessment instrument should be used to assess continence on admission and when the resident's status changed. He/she confirmed that resident #004's continence had not been reassessed when there had been a change in bladder continence.

In an interview, DOC #101 confirmed that compliance order #002 had not been complied with. He/she also stated that the home had not been aware of the order. [s. 51. (2) (a)]
(502)

3. During an interview, resident #066 stated that after a specified amount of time the incontinence care product felt soiled and he/she would experience an unpleasant sensation. Resident #066 further stated that his/her incontinence care product is only changed once per shift and that during the night shift he/she had not been changed or provided proper hygiene by the staff #201. Resident #006 further stated that staff #201 usually tells him/her to wait for the next shift due to lack of supplies. The resident also stated he/she had regularly experienced infections.

Review of resident #066's most recent written plan of care revealed the resident is incontinent and staff are to ensure the resident is clean and dry at all the times. An individualized toileting plan had not been included in the plan of care.

In an interview, staff #201 stated that he/she had been usually changing the resident as per request, but that two to three times each month he/she would inform resident #066 of the lack of supplies and leave him/her to wait for the next shift to be changed.

In an interview, staff#126 confirmed that the resident should have been changed as needed and that an individualized toileting plan had not been included in resident #066's plan of care. [s. 51. (2) (b)]
(502)

4. The MOHLTC ActionLine received a complaint related to continence care for residents in the home. The complainant stated that resident #027 was transferred to his/her wheelchair and wheeled to the elevator while his/her incontinence care product and bed were visibly soiled.

The inspector observed staff #162 changing resident #027's incontinence care product in bed. In interviews, staff #162 and #195 stated that resident #027required to be changed in bed related to impaired mobility.

Review of resident #027's individualized resident assessment revealed resident #027 had been frequently incontinent of bowel and bladder, had been able to maintain their mobility as determined during a physiotherapy sitting balance test and had required extensive assistance of two staff for toilet use. Further review of resident #027's plan of care revealed resident #027 had cognitive loss related to an underlying health condition which impaired decision making and the ability to communicate clearly. An individual toileting plan to promote and manage bowel and bladder continence had not been identified in the plan of care.

In an interview, staff #140 stated that resident #027's ability to request assistance with toileting had declined, but he/she would exhibit responsive behaviours when he/she needed to void or require a incontinence product change. Staff #140 also stated that resident #027 had been able to maintain continence of bowel and bladder if toileted, but an individualized toileting plan had not been developed for resident #027.

In an interview, staff #126 confirmed that resident #027 should have been toileted and that an individualized toileting plan had not been included in the plan of care. [s. 51. (2) (b)] (502)

5. The licensee has failed to ensure that continence care products are not used as an alternative to providing assistance to toilet.

A CIS report was submitted to the Ministry of Health and Long-Term (MOHLTC) related to residents not being treated with dignity and respect.

Review of the CIS report and home's investigation notes revealed resident #008 had requested assistance with toileting and that staff #155 had told resident #008 to void in their incontinence care product. Resident #008 had told his/her spouse that he/she would not do that.

In an interview, staff #155 stated that he/she had told resident #008 to void in his/her incontinence care product if staff were not available and he/she would not mind cleaning the resident later.

In an interview, staff #133 confirmed that staff #155 had told resident #008 to void in their incontinence care product.

In an interview, staff #126 who is the continence lead confirmed the above mentioned incident and stated that staff had been advised to toilet residents more often and not to use the incontinence care product as a substitution to toileting. (502)

6. The licensee has failed to ensure that continence care products are not used as an alternative to providing assistance to toilet.

Review of a CIS report submitted to the MOHLTC, revealed that at a specified time resident #004 requested assistance with toileting. The resident's family member and staff #156 had repeatedly requested to have resident #004 toileted by several staff members. The resident was eventually toileted two and one half hours later.

In an interview, resident #004 stated that he/she had been toileted in the morning, and that no one had checked on him/her in the afternoon. The resident stated due to an identified medication that he/she urinated frequently and most of the time felt uncomfortable. The resident also stated that he/she had requested to wear two products to stay dry as when he/she requests to be toileted, he/she usually has to wait until his/her assigned time.

Review of the home's training material for bowel and bladder care titled: Tena Tips: Double Padding For Long-Term Care, revealed that double padding can increase the risk for unnecessary discomfort and skin irritation.

In interviews, staff #110 and #129 stated that additional protection had been applied inside the resident's incontinence care product.

In interviews, staff #161 and staff #126 confirmed that the practice of additional protection had not been allowed in the home and staff had been directed to toilet residents more often instead of relying on the incontinent care products. [s. 51. (2) (e)]

The scope of finding is related to four residents, the severity is identified to be minimal and potential for actual harm in that residents expressed physical discomfort and emotional responses in relation to not being assisted with toileting. Previous history identified a compliance order had been served under inspection #2016_226192_0014 on April 25, 2016 with a compliance due date of June 30, 2016. Due to this ongoing non-compliance under O. Reg. 79/10. r. 51., a compliance order is warranted.
(502)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 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

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

Mar 10, 2017

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. 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.

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that any identifying factors or triggers are identified and steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

The plan will include, at a minimum, the following elements:
-Provide education to all staff that enables them to recognize potential triggers and factors and not to normalize any responsive behaviours demonstrated by residents and,
-Develop an interdisciplinary process that identifies residents that exhibit responsive behaviors and the implementation of interventions,

Please submit the plan to Joanne.Zahur@ontario.ca no later than January 20, 2017.

Grounds / Motifs :

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

A CIS was submitted to the MOHLTC related to an incident of resident to resident aggression that had occurred on the same day.

Review of the CIS revealed that resident #013 had been seated in the dining room. When resident #013 had been directed by staff to move he/she struck resident #002 who had been sitting at the same table. The incident caused an injury to resident #002.

The CIS further revealed that resident #013 had been exhibiting responsive behaviours that day.

Review of the progress notes between an identified six month period revealed resident #013 had been exhibiting multiple incidents of responsive behaviours daily.

Review of resident #013's most recent written plan of care revealed that a responsive behaviour observation monitoring form was to be completed each shift for any responsive behaviours exhibited.

In an interview, staff #101 stated that resident #013 had a history of exhibiting responsive behaviours and the home had initiated one-to-one (1:1) monitoring on previous occasions. Staff #101 stated that 1:1 monitoring had been in place over the following time frames related to responsive behaviours:
-on identified dates between December and February 2016,
-on identified dates in May 2016; and
-from an identified date in July 2016, to present.

Review of progress notes for resident #013 revealed that at the time of the above mentioned incident there had not been any 1:1 monitoring in place, however this intervention had been re-initiated after the above mentioned incident.

In an interview, staff #101 stated that 1:1 monitoring had been re-initiated after an incident had occurred between residents #013 and #014 and again after the above mentioned incident between residents #013 and #002. Staff #101 further stated that the documentation of registered staff had normalized resident #013's responsive behaviours.

In an interview, staff #100 stated that the registered staff had been responsible to ensure the responsive behaviour form had been completed every shift by the staff member assigned to 1:1 monitoring. Staff #101 further stated that by not consistently ensuring the completion of the responsive behaviour form he/she had fallen short of fulfilling his/her responsibility in identifying any risk of altercation and potentially harmful interactions between resident #013 and other residents.

In an interview, staff #101 confirmed that normalizing resident #013's responsive behaviours had failed to ensure that steps had been taken to minimize the risk of altercations and potentially harmful interactions between resident #013 and other residents by identifying and implementing interventions.

The severity of this finding is identified as actual harm, the scope is isolated to one resident and the previous compliance history identified a previous written notice with a voluntary plan of correction had been issued. As a result of this ongoing non-compliance with O. Reg. 79/10, s. 54(b), a compliance order is warranted. [s. 54. (b)] (589)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 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

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

Mar 10, 2017

Order # /
Ordre no : 006

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

Linked to Existing Order /
Lien vers ordre existant: 2016_226192_0014, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 99. Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 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

The licensee shall prepare and submit a plan to ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken and an annual evaluation of the effectiveness of the Prevention of Abuse policy is completed.

The plan will include, at a minimum, the following elements:
-A system to ensure an analysis of every incident of abuse is undertaken and,
-A system to ensure that once a calendar year an evaluation is completed of the effectiveness of the Prevention of Abuse program in the home that identifies changes and improvements required.

Please submit the plan to Joanne.Zahur@ontario.ca no later than January 20, 2017.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Grounds / Motifs :

1. The licensee has failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home was undertaken promptly after the licensee becomes aware of it.

A CIS report was submitted to the MOHLTC related to a complaint about alleged staff to resident abuse. The CIS revealed that resident #007 reported that an evening staff member had spoken to him/her in a discourteous manner and that he/she was no longer comfortable receiving care from this particular staff member.

Review of the home's Complaints and Concerns binder revealed that an analysis of this complaint had not been undertaken.

In an interview, staff # 123 confirmed the home had not undertaken an analysis of the above mentioned complaint as they had focused on the staff's non-compliance related to the above mentioned incident.

The severity of this finding is minimal risk, the scope is isolated to one resident and the previous compliance history identified a previous compliance order had been served with a compliance date in June 2016. As a result of this ongoing non-compliance with O. Reg. 79/10, s. 99(a), a compliance order is warranted. [s. 99. (a)] (600)

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

Feb 24, 2017

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 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

Order # / 007 **Order Type /** Compliance Orders, s. 153. (1) (b)
Ordre no : **Genre d'ordre :**

Linked to Existing Order / 2016_349590_0010, CO #001;
Lien vers ordre existant:

Pursuant to / Aux termes de :

O.Reg 79/10, s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency;
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency;
(c) conduct a planned evacuation at least once every three years; and
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure emergency plans are tested as per legislative requirements.

The plan will include, at minimum, the following elements:
-A process that ensures that the loss of essential services, fires, missing resident incidents, medical emergencies and violent outbursts are tested annually,
-A process that ensures a planned evacuation of the home is conducted at least once every three years,
-A system that allows for a written record of emergency plan testing and planned evacuations that identifies changes made to improve the plan to be kept and,
-A system that keeps a record of arrangements in place with community agencies, partner facilities and resources.

Please submit the plan to Joanne.Zahur@ontario.ca no later than January 20, 2017.

Grounds / Motifs :

1. The licensee shall ensure that following emergency plans are tested every three years and that a written record is kept of the completed tests identifying changes made to improve the following plans:
- emergency evacuation plan, and
- bomb threat plan.

In April 2015, the home received a compliance order related to testing the emergency plans during a critical incident inspection. The order indicated the home was to be in compliance by an identified date in March 2016.

In June 2016, the home received a second compliance order related to testing the emergency plans during a follow-up inspection. The order indicated the home was to be in compliance by an identified date in July 2016.

Record review of the home's emergency binder revealed the emergency evacuation plan and the bomb threat plan had not been tested as per the two identified compliance orders.

During interviews conducted on two identified dates in September 2016, with staff #106 and staff #103 respectively, both confirmed that the home's emergency evacuation plan and bomb threat plan had not been tested.

A Mock Evacuation Project "Code Green" plan was provided to the inspector by staff #103. Staff #103 stated that the home has been scheduled to complete the test of the emergency evacuation plan on an identified date in October 2016. Staff #103 stated that all community agencies, including local fire department, police department, and emergency medical services had not been invited to participate by the date of this inspection.

Staff #103 also stated that the goal for the home had been to test the bomb threat plan by an identified date in October 2016, before accreditation takes place in the home; however a plan was not provided to the inspector to support this statement.

The scope of this finding had been identified in two previous inspections and therefore is a pattern. The severity is a potential for harm, and the previous compliance history revealed that a compliance order had been served with a compliance date in March 2016, and in June 2016 a second compliance order with a compliance date in July 2016, had been served due to ongoing non-compliance. As a result of two previous compliance orders having been served and continued non-compliance with O. Reg. 79/10 r. 230 (7), a Director's Referral is warranted. [s. 230. (7)] (502)

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

Feb 10, 2017

(A1)
The following Order has been rescinded:

Order # / Ordre no : 008 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order # / Ordre no : 009 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The plan will include, at a minimum, the following elements:
-Provide education to all staff so that they understand the different types of abuse and neglect,
-Provide education to all staff regarding the Residents' Bill of Rights,
-Develop a system to ensure all staff receive education on abuse prevention and neglect and Residents Bill of Rights upon hire and annually, and
-Develop a system to randomly audit staff to resident, resident to resident, and visitor to resident interactions.

Please submit the plan to Joanne.Zahur@ontario.ca no later than January 20, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are free from neglect by the licensee or staff in the home.

A CIS report submitted to the MOHLTC revealed that resident #019 had complained to staff #126 that a dressing he/she required was not being changed frequently. The CIS further revealed that staff #207 became upset when staff #126 reminded him/her to complete the dressing change as he/she stated that the dressing change was always completed when he/she was on shift. The CIS also revealed that resident #019 stated to staff #126 that staff #207 had spoken inappropriately towards him/her had made him/her feel guilty for complaining that some nurses were not completing the dressing changes.

In an interview, resident #019 stated that staff #207 had changed the dressing time to day shift from evenings. Resident #019 further revealed that he/she was absent from the home two to three times per week and preferred to have the dressing changed on evening shift, and that staff #207 walked out of the resident's room without listening to his/her request to keep the dressing changes on the evening shift.

In an interview, staff #126 confirmed the above mentioned complaints voiced by resident #019.

Review of the most recent written plan of care revealed that resident #019 was cognitively intact.

Review of the treatment administration records (TAR) revealed that the dressing had been completed daily on the evening shift except for a specific date in July 2016, where it had been completed on day shift. Further review of the TAR revealed the dressing had been changed back to the evening shift.

In an interview, staff #207 stated that he/she thought since resident #019 was bathed on the day shift, the dressing should be changed then. Staff #207 further stated that he/she had not been aware that resident #019 had not wanted the dressing time changed and admitted he/she had made a mistake. Staff #207 denied in an interview that he/she actions had been inappropriate or that he/she had spoke inappropriately to resident #019.

Review of the home's internal investigation notes revealed that resident #019's complaint had been verified and that the home had issued disciplinary action to staff #207.

In an interview, staff #101 confirmed that resident #019 had not been protected from abuse.
(589)

2. A CIS report submitted to the MOHLTC revealed that resident #002 had been abused by staff #209. The CIS revealed that when resident #002 had asked for assistance with his/her meal, staff #209 replied using inappropriate language and comments and leaving the room without assisting resident #002. The CIS further revealed resident #002 cognitively intact.

In an interview, resident #002 stated that he/she had sustained an injury that had impaired his/her mobility. Prior to the injury resident #002 had been mobile with a mobility aid and required one person assist for transfers, and was independently taking all meals in the dining room. As a result of the injury resident #002 had been taking meals in his/her room.

Resident #002 had been experiencing weakness in an identified body area and had asked staff #209 for some assistance with his/her meal tray. Resident #002 further stated that sometimes when staff #209 talks, it sounds inappropriate, and that sometimes he/she is very good but other times is not.

Review of home's investigation notes revealed that in an interview resident #002 had further revealed staff #209 told him/her to feed him/herself as he/she was not injured.

In an interview, staff #209 denied that he/she had spoken to resident #002 as described above and stated that he/she never would speak to any resident in that way.

Review of staff 209's personnel file revealed he/she had previously received discplinary action for speaking inappropriately to a resident.

In an interview, staff #101 stated that as a result of the home's investigation and staff #209's prior disciplinary history, he/she would be given further disciplinary action related to this incident. Staff #101 confirmed that resident #002 had not been protected from abuse. [s. 19. (1)]
(589)

3. A CIS report submitted to the Ministry of Health and Long Term Care (MOHLTC) revealed that resident #052's family member had reported that resident #052 was abused by staff #188.

Record review of the interdisciplinary care conference notes (ICCN) revealed that resident #052 was cognitively intact.

In an interview, resident #052 revealed he/she had been abused by staff #188.

In an interview, resident #052's family member revealed he/she had witnessed staff #188 abuse his/her spouse.

In an interview, staff #188 denied the allegation that he/she had abused resident #052.

In an interview, staff #103 stated that had the alleged actions taken place, would have constituted abuse by the definition set out by the Regulations; however he/she denied that the licensee had failed to protect resident #052 from abuse.

In interviews, resident #052 and resident #052's family member revealed there had been two incidents of abuse of resident #052 by staff #188. In this case the licensee failed to ensure that resident #052 was protected from abuse by anyone. [s. 19. (1)] (643)

4. A CIS report was submitted to the MOHLTC related to staff to resident abuse.

In an interview, resident #006 stated that he/she had requested staff #137 to wash him/her properly using a basin, with warm, soapy water and a towel. Staff #137 told the resident that the basin was in the washroom and he/she did not have the time to get it. Staff #137 then got a damp towel, wrung it out and wiped resident #006 with it. He/she then asked the resident to turn around and used the same dirty towel to wipe him/her again. Resident #006 also reported that staff#137 had provided improper morning care on other occasions and that he/she had apologized, however resident #006 was pleased that staff #137 no longer provided care to him/her.

In an interview, staff #137 stated he/she had not used the basin as per resident #006's request. Staff #137 also stated he/she had not known that not using the basin would hurt resident #006's feelings and had apologized to the resident.

In an interview, staff #101 confirmed that staff #137's action had been deemed inappropriate and unprofessional, and that resident #006 had been emotionally affected by the PSW's action. [s. 19. (1)]
(502)

5. A CIS report was submitted to the MOHLTC related to resident neglect.

Review of the CIS report revealed that resident #004 had requested assistance with toileting. The resident's family member and private care giver repeated the request to toilet resident #004 on numerous times between identified hours to several staff members. Resident #004 eventually was toileted two and one half hours later.

Review of the resident assessment instrument revealed resident #004 was continent of bowel and incontinent of bladder. Resident #004 required extensive assistance from two staff for identified ADL's.

Review of resident #004's written plan of care revealed resident #004 had used a toileting aid requiring the assistance of two staff. The plan of care also revealed that resident #004's incontinence care product had to be changed at two specified times during the day shift and a specified time in the evening shift with the aid of a

mechanical apparatus.

In an interview, resident #004 stated he/she had experienced urinary incontinence and had been experiencing the urge to have a bowel movement. Resident #004 further stated he/she had informed staff #156 that needed to be toileted and to call for staff assistance. Resident #004 stated that he/she was eventually toileted two and one half hours later at which time he/she had also been incontinent of bowel.

In an interview, staff #156 stated the following:
-staff #156 informed staff #129 that resident #004 needed assistance with toileting on four identified times,
-staff #156 informed staff #161 at a identified time that resident #004 needed to be toileted,
-the resident's family member informed staff #193 at an identified time that the resident needed to be toileted,
-staff #156 observed staff #129 pouring water in the dining room, and informed him/her at an identified time that the resident had been incontinent of bladder and bowel and required to be changed prior to dinner,
-staff #156 stated that resident #004 had told him/her to stop asking for assistance because staff never assisted him/her before the scheduled toileting time, and
-at an identified time after dinner, resident #004 was toileted, washed and transferred to bed, which was two and half hours after the initial request for assistance.

In an interview, staff #129 stated that staff #161 had informed him/her that resident #004 needed assistance with toileting. Staff #129 also stated that staff #161 had advised him/her to tell resident #004 that he/she had other residents to get out of the bed and that resident #004 would have to wait until his/her assigned toileting time. Staff #129 stated he/she had informed resident #004 that other staff members on duty were providing showers to residents and a second staff was needed for his/her transfer to the toileting aid, however staff #129 believed nobody was willing to assist as it takes at least an hour to toilet this resident.

In an interview, staff #161 stated that he/she had informed staff #129 and #193 about resident #004's request to be toileted, but had not been aware that resident #004 had not been toileted as requested.

In an interview, staff #193 stated he/she had told staff #129 to stop setting the dinner table and to toilet resident #004 right away, but staff #129 had ignored him/her.

Interviews with staff #126 and #101 confirmed that resident #004's toileting care needs had been neglected. They further stated that staff #129 had been disciplined regarding the above mentioned incident [s. 19. (1)]

The severity of this non-compliance is potential for actual harm related to residents' emotional well-being, dignity and respect, incidence of verbal abuse and inappropriate touching, the scope is a pattern as relates to five incidents reviewed in this inspection. Previous compliance history includes a written notice with a voluntary plan of action was issued. As a result of ongoing non-compliance with O. Reg., s. 19., a compliance order is warranted. [s. 19. (1)]
(502)

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

Mar 10, 2017

Order # /
Ordre no : 010

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that the care set out in the plan of care is provided to the residents as specified in the plan.

The plan will include, at minimum, the following elements:
-a monitoring process that ensures residents are positioned safely for eating as outlined in the plan of care.
-a process that ensures residents who are at risk of falling have falls prevention interventions implemented as per the plan of care including the use of hip protectors if indicated.
-include in the compliance plan a system that outlines how the licensee will be monitoring staff adherence to resident plans of care.

Please submit the plan to Joanne.Zahur@ontario.ca no later than January 20, 2017.

Grounds / Motifs :

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

A CIS report was submitted to the MOHLTC which revealed resident #021 had experienced a fall sustaining an injury.

Further review of the CIS revealed the night staff had been dressing the resident before the day staff started their shift and had been applying the body protectors bilaterally to resident #021. The CIS also revealed resident #021 had been unsettled that morning prior the fall and had undressed him/herself on several occasions requiring staff to repeatedly dress him/her. However no one had checked to ensure the body protectors remained in place each time resident #021 had been re-dressed.

Review of resident #021's most recent written plan of care revealed the resident had been identified at high risk for falls and that one of the interventions was to have body protectors applied to decrease fall-related injury.

Review of the Post Fall Huddle revealed that at the time of the fall resident #021 had not been wearing body protectors as indicated in the written plan of care.

Observations by the inspector revealed resident #021 did not have body protectors in

place.

In an interview, staff #149 stated he/she had been aware of resident #021's plan of care directing the staff to apply body protectors to prevent injury. Staff #149 further revealed resident #021 had been dressed by the night staff and that he/she had just changed the resident once at an identified time.

In an interview, staff #149 stated that when he/she had changed resident #021 he/she noted the body protectors had not been applied, however he/she still seated resident #021 in a mobility aid.

In an interview, staff #113 stated resident #021 had been identified at risk for falls and he/she was to have body protectors applied to decrease fall-related injury. Staff #113 further confirmed that body protectors had not been applied and that staff #149 had not provided care to resident #021 as per the plan of care.

In an interview, staff #138 confirmed that staff had not provided care to resident #021 as per the plan of care. [s. 6. (7)] (600)

2. Observation by the inspector revealed that resident #050 was being assisted with feeding by staff #163. Resident #050 was observed to be in a reclined position while being fed. Subsequent observations by the inspector revealed that resident #050 continued to be assisted with feeding by staff #102 while he/she was seated in a reclined position.

Record review of resident #050's most recent written care plan revealed he/she required total assistance from staff for eating, and was at high risk for aspiration. Resident #050 was to remain seated upright during and thirty minutes after meals. Resident #050's diet order included that he/she was to be fed a specific amount at a time.

In an interview, staff #111 stated this was not the correct feeding position as per resident #050's written plan of care and that he/she should have been positioned in an upright position while being fed.

In an interview, staff #101 confirmed that by feeding resident #050 in a reclined position, staff #102 and #163 had not been providing care as set out in the plan of care. [s. 6. (7)]
(643)

3. A CIS report was submitted to the MOHLTC revealed resident #022 sustained an injury after a fall that required a transfer to hospital for further assessment.

Further review of the CIS revealed that resident #022 had falls prevention interventions in place prior to the fall included:

Immediate actions to prevent recurrence included identified falls prevention interventions specific to resident #022.

Review of the most recent written plan of care revealed a falls risk focus that identified resident #022 at high risk for falls. The plan of care was updated to include the above mentioned immediate actions to prevent recurrence of falls. Review of the kardex located on the point of care (POC) screens accessed by staff revealed under the safety focus to put into place identified falls prevention interventions.

Observations on two identified dates by the inspector revealed resident #022 was lying in bed with no identified falls prevention interventions in place.

In interviews, staff #140 and #139 stated that the above mentioned falls prevention interventions had not been in place.

In an interview, staff #138 confirmed that the care set out in the plan of care had not been provided as specified in the plan. [s. 6. (7)]

The severity of this non-compliance is potential for harm related to improper positioning when feeding, and care not provided as per the plan of care related to fall prevention interventions. The scope is isolated to three residents, and previous compliance history identified a compliance order under the LTCHA 2007, s. 6 had been served in RQI inspection #2015_324567_0015 with a compliance date of February 26, 2016. As a result of ongoing non-compliance with O. Reg. s. 6., a compliance order is warranted.

(589)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le :

Mar 10, 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 or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

Ministère 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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6 day of February 2017 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JOANNE ZAHUR - (A2)

Service Area Office /
Bureau régional de services : Toronto