Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 7, 2015	2015_303563_0015	L-001951-15	Resident Quality Inspection

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE SUITE 800 LONDON ON N6A 1K7

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

WESTMOUNT GARDENS LONG TERM CARE HOME
590 Longworth Road LONDON ON N6K 4X9

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

MELANIE NORTHEY (563), CHRISTINE MCCARTHY (588), INA REYNOLDS (524), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 13 -17, 21-23, 2015

The following Critical Incident inspections were conducted concurrently during this inspection:
Log # 002076-15 / 2878-000005-14
Log # 004412-15 / 2878-000009-14
Log # 004193-15 / 2878-000011-14
Log # 005267-14 / 2878-000076-14 (on site inquiry)
Log # 005622-14 / 2878-000077-14 & 2878-000086-14
Log # 005815-14 / 2878-000080-14
Log # 007752-14 / 2878-000090-14
Log # 007775-14 / 2878-000092-14
Log # 008961-14 / 2878-000099-14
Log # 009107-14 / 2878-000100-14
Log # 000451-15 / 2878-000101-14
Log # 004259-15 Anonymous Complaint

During the course of the inspection, the inspector(s) spoke with the Director of Clinical Services and Education, the Administrator, the Manager of Resident Care, the Manager of Nutrition Services, one Dietary Aide, the Environmental Services Manager, four Housekeepers, the Physiotherapist, the Restorative Care Manager, the Resident Assessment Instrument Coordinator, the Manager of Social Services, two Resident Care Coordinators, two Registered Nurses, eight Registered Practical Nurses, 18 Personal Support Workers, the Resident Council President, two Family Council Representatives, 44 Residents and four Family Members .

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident related to the use of side rails.

Room observation for Resident # 3 revealed a side rail in use.

Record review of the current care plan revealed there were no interventions in place for the use of this side rail for Resident # 3.

Record review of Minimum Data Set (MDS) Assessments in section P4b: Devices and Restraints revealed the resident used one side rail daily.

Staff interview with the Resident Assessment Instrument (RAI) Coordinator confirmed the MDS Assessments completed indicated the use of side rails.

Staff interview with the Resident Care Coordinator (RCC) confirmed that Resident # 3 should have the use of one side rail indicated in the care plan and that interventions

should be listed on the Personal Support Worker (PSW) Kardex related to the use of one side rail. RCC confirmed the plan of care does not provide clear directions for the use of side rails. [s. 6. (1) (c)]

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

Record review of the Physician's orders for Resident # 14 revealed an order for a non-narcotic analgesic to be administered as needed (PRN). There was also an order for a regular standing narcotic medication to be administered routinely.

Record review of the electronic Medication Administration Record (eMAR) revealed the narcotic medication was not administered as ordered by the physician.

Record review of the progress notes revealed Resident # 14 did not receive the non-narcotic analgecic medication PRN in the absence of the routine narcotic medication.

Record review of the home's investigation notes and interview with the Administrator confirmed Resident # 14 did not receive the narcotic medication as prescribed and the PRN pain medication was not administered in it's place. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan for Resident # 19.

A) Record Review of progress notes, a critical incident and staff interview revealed Resident # 19 exhibited responsive behaviours towards other residents.

Record review of the most recent care plan on PointClickCare (PCC) for Resident # 19 revealed the Behaviour Supports Ontario (BSO) interventions directed staff to check the resident at routine intervals.

Observations of Resident # 19 revealed those routine checks were not initiated.

Interview with a PSW confirmed the resident exhibits responsive behaviours and the PSW shared that they need to monitor the resident routinely.

Interview with the RAI Coordinator confirmed there was no documented evidence that routine checks for responsive behaviours were completed for Resident # 19 and

confirmed the expectation that the care set out in the plan of care is to be provided to the resident as specified in the plan.

B) Resident # 19 was observed to be lying in bed one side rail in use.

Record review of the most recent quarterly MDS Assessment under the devices and restraints section for Resident # 19 revealed the resident requires one side rail up while lying in bed. Record review of the most recent care plan and Kardex on Point of Care (POC) revealed the information from the MDS assessment was not included in the care plan and no direction was provided to staff regarding use of the side rail.

A PSW shared that Resident # 19 has two full rails in use while in bed.

The RAI Coordinator confirmed that Resident # 19 should not have side rails up and there are discrepancies related to side rail use. The RAI Coordinator further confirmed the expectation that the care set out in the plan of care is provided to the resident as specified in the plan.

C) Record review of the most recent care plan and Kardex for Resident # 19 under the fall prevention focus directed staff to ensure the call bell is within reach.

Resident observation revealed Resident # 19 was observed to be lying in bed, the call bell was not accessible to the resident and was found beside the bed on the floor.

A PSW confirmed the call bell was on the floor and further shared that the call bell can be clipped to residents' clothing or to the bed.

The RAI Coordinator confirmed that it is the home's expectation that resident call bells are to be within the residents reach when in their room and that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan related to the use of positioning aides and a specialized garment.

A) Observation of Resident # 8 revealed the resident was not positioned properly. Three staff members walked past this resident without repositioning and putting aides in place.

Record review of the current care plan revealed the positioning aides should be in the up position when resident is sitting stationary in the wheelchair.

B) Interview with a family member of Resident # 8 revealed the resident was not wearing the specialized garment during a recent visit. The family member shared that the specialized garment was in disrepair.

Observation of Resident # 8 revealed the resident was not wearing the specialized garment.

Record review of the current care plan and Kardex for Resident # 8 revealed there were no interventions documented for the use of the specialized garment.

Staff interview with two PSWs confirmed Resident # 8 uses the specialized garment daily and confirmed this intervention is not documented on the Kardex. [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan related to use of the call bell.

Record review of the current care plan for Resident # 9 revealed an intervention to ensure the call bell is within reach.

Resident observation revealed the call bell was tied to right side rail several feet away from Resident # 9 who was sitting at the end of the bed facing the window.

Staff interview with the Registered Nurse (RN) confirmed that the resident's call bell should be within reach and have a clip to secure it to the resident. [s. 6. (7)]

6. The licensee has failed to ensure that the plan of care was 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.

Record review of the current care plan for Resident # 8 revealed medical interventions in place related to a previous injury. The injury has since healed and the care plan was not updated to reflect this change.

Staff interview with the Physiotherapist (PT) revealed it is the responsibility of the PT to update the care plan for all residents receiving 1:1 PT services and care plans are

reviewed at least quarterly and changes are made as needed. The PT confirmed that with the completion of the MDS Assessment for Resident # 8 the physio care should have been updated to reflect that the resident no longer requires these medical interventions related to a previous injury. [s. 6. (10) (b)]

7. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to the use of hearing aides.

Record review of the MDS Assessment revealed Resident # 19 was assessed to be impaired of hearing. Record review of the most recent care plan for Resident # 19 indicated that the resident has hearing aides.

Staff interview with the Personal Support Worker (PSW) and progress note review revealed the resident has not worn hearing aids for some time. Interview with a family member confirmed the resident no longer uses hearing aides.

The RAI Coordinator confirmed the care plan was not revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that the plan of care was 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 #2: 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 "Bladder and Bowel Continence Policy" put in place is complied with.

Record review on April 15, 2105 revealed evidence that there is a Continence Assessment Tool in PCC. There was no documented evidence of a clinically approved Continence Assessment completed for Resident # 6 by the Registered staff.

Review of the "Bladder and Bowel Continence Policy" on April 15, 2015 revealed. " 1. A complete continence assessment will be completed if H4 Change in Urinary and/or Bowel Continence is coded as "deteriorated" during Quarterly Minimum Data Set (MDS) or change in status. If coded as no change no further action is required."

Interview with a Registered Practical Nurse (RPN) revealed that the home did not complete a Continence Assessment on Resident # 6 when bladder continence according to the most recent MDS assessment was coded as a worsening of bladder continence.

Interview with the Administrator confirmed that the home did not use the available electronic clinically appropriate assessment instrument specifically designed for assessment of continence for Resident # 6. [s. 8. (1) (b)]

2. Record review of the previous MDS Admission Assessments for Resident # 56 revealed this resident was continent in both bowel and bladder.

Record review of the most recent MDS Quarterly Assessment revealed the resident's bladder function deteriorated.

Interview with the Resident Assessment Instrument (RAI) Coordinator confirmed there was no Continence Assessment completed in PCC in response to the change in status indicated in the MDS Quarterly Assessment.

Interview with the RPN confirmed that the hard copy chart does not contain a Continence Assessment other than the Admission Continence Assessment. [s. 8. (1) (b)]

3. The licensee failed to ensure that the "Weight & Height Monitoring Policy" is complied with.

Census review of the 40 resident sample in stage 1 of the Resident Quality Inspection revealed multiple residents have not been measured for height as early as 2012.

Record review of the "Weight & Height Monitoring Policy" on April 21, 2015 revealed, "All residents height will be measured in centimeters upon admission and annually thereafter."

Record review of the "Westmount Gardens Weights and Vitals Summary" Report revealed 49 of 160 (30.6 %) residents were measured for height in 2014.

Staff interview with the Director of Clinical Services and Education confirmed all residents are to be measured for height annually. [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 "Bladder and Bowel Continence Policy" and the "Weight & Height Monitoring Policy" otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Resident observations conducted on April 13 and 14, 2015 revealed 23 of 40 residents (58%) had one to two bed rails in use. Multiple beds were observed where mattresses moved freely with no keepers in place.

Staff interviews with two Registered Nurses (RN) on April 13 and 14, 2015 confirmed mattresses were easily moved with little effort and slid freely. Both RNs shared that a bed entrapment audit was scheduled for April 2015.

Staff interview with the Director of Clinical Services and Education confirmed that this is the first entrapment audit for the home and no resident has a bed rail assessment completed and the home has no formal bed rail risk assessment in place. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #4: 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 a resident-staff communication system is available in every area accessible by residents.

Observation of the Snoezelen Room on the second floor on April 13, 2015 at 1000 hours revealed the room was not equipped with a resident staff communication system.

Interview with a Personal Support Worker (PSW) revealed the Snoezelen Room does not have a call bell system that is accessible to residents.

Staff interview with the Director of Clinical Services and Education confirmed that the home does not have a resident staff call bell system in the Snoezelen Room that is accessible to residents and staff. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident-staff communication system is available in every area accessible by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines. O. Reg. 79/10, s. 26 (3).
2. Cognition ability. O. Reg. 79/10, s. 26 (3).
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).
4. Vision. O. Reg. 79/10, s. 26 (3).
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).
7. Physical functioning, and the type and level of assistance that is required

relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).
19. Safety risks. O. Reg. 79/10, s. 26 (3).
20. Nausea and vomiting. O. Reg. 79/10, s. 26 (3).
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming, dental oral status and sleep patterns / preferences for Resident # 3.

Record review of the Kardex for Resident # 3 revealed there was no reference to the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming, dental oral status and the resident's sleep patterns / preferences.

Record review of MDS Assessment revealed the resident was documented for indicators of mood and sleep disturbance.

Record review of the current care plan for Resident # 3 revealed there were no focus statements, goals or interventions related to the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming, dental oral status and the resident's sleep patterns / preferences.

Staff interview with the Resident Care Coordinator (RCC) confirmed that the Kardex for Resident # 3 had minimal interventions related to the care for this resident. The RCC and the Administrator confirmed the PSWs use the Kardex and logos as a guide to provide care to the residents and confirmed new PSW staff would not have the necessary documentation in place to provide accurate and safe care for this resident. [s. 26. (3)]

2. The licensee has failed to ensure that a plan of care must be based on, at a minimum, an interdisciplinary assessment of the following with respect to the resident sleep patterns and preferences.

Record review of the most recent Minimum Data Set (MDS) Quarterly Assessment under the mood and behaviour section for Resident # 19 indicated the resident had sleep-cycle issues.

Interview with a family member revealed it was the resident’s preference to take a nap after lunch each day.

Record review of the care plan on PointClickCare for Resident #19 revealed the resident’s sleep patterns and preferences were not included in the plan of care as based on the interdisciplinary assessment. [s. 26. (3) 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming, dental oral status and sleep patterns / preferences., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Record review of MDS Assessment for Resident # 3 revealed the resident had multiple mood and behaviours occurring several days a week.

Record review of the Behaviour Task and Mood Task revealed several different mood/behaviours occurred that were not easily altered.

Record review of the current care plan revealed mood and behaviour symptoms did not have strategies developed and implemented to respond to the resident demonstrating all responsive behaviours.

Staff interview with the Resident Assessment Instrument (RAI) Coordinator confirmed all mood and behaviour concerns are to be care planned for each resident and interventions provided for the PSWs related to mood and behaviours must be linked to the Kardex. The RAI Coordinator also confirmed that Resident # 3 does not have care plan interventions in the plan of care related to the indicators of mood and behavioural symptoms as documented in the most recent MDS Assessment. [s. 53. (4) (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 strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the retraining for staff in infection prevention and control includes cleaning and disinfection practices.

Record review of the Mandatory / Annual Training Session for 2014 revealed staff members across all disciplines did not receive the mandatory retraining on Infection Prevention and Control that includes cleaning and disinfection practices.

Staff interview with the Director of Clinical Services and Education on April 16, 2015 confirmed the home did not provide mandatory retraining for all staff on cleaning and disinfection practices as part of the infection prevention and control program. [s. 219. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes cleaning and disinfection practices, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observation of shared resident bathrooms revealed:
- multiple used and unlabeled personal care items
- unlabeled wash basins found on the floor
- an unlabeled urine collector on the floor
- multiple call bell cords were stained and soiled
- one bathroom call bell cord was observed to be placed on the back of a toilet seat and another was lying on the bathroom floor
- light cords above beds were soiled and brown in colour
- two used and unlabeled slipper pans in shared bathroom, one positioned on toilet bowl tank and two used, soiled and unlabeled pink basins on counter top
- used gloves on bathroom floor folded into each other
- armchair soiled with a brown stain on the seat cushion

A registered nurse and housekeeping staff confirmed call bell cords were stained and soiled. An interview with the Director of Clinical Services and Education revealed that the call bell cords in resident washrooms will be replaced with vinyl cords. The Environmental Services Manager revealed the home's expectation is that all call bell cords in resident bathrooms are cleaned and disinfected daily. (524) [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Critical Incident (CI) Report # 2878-000092-14 was reviewed on April 22, 2015. There was no "Amended" version of the Critical Incident after the initial submission.

Interview with the Administrator revealed there was no documentation found related to this investigation. The Administrator confirmed it is the home's expectation to follow up all critical incidents with an investigation and make amendments to the Critical Incident Report.

Record review of the "Resident Abuse & Neglect Policy" revealed, “Administration shall investigate the circumstance surrounding the incident. Any parties involved must provide a signed, written statement of the incident. The Home will follow the investigation process outlined in Human Resources Policy.” [s. 23. (2)]

2. Critical Incident Report #2878-000080-14 was reviewed on April 22, 2015. There was no "Amended" version of the Critical Incident after the initial submission.

Interview with the Administrator on April 23, 2015 confirmed that results of the investigation undertaken were not reported to the Director in an amendment to the Critical Incident. [s. 23. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Record review of the "Resident Abuse & Neglect Policy" revealed, "Notification of Resident/Family Legal Representation - Administration will contact the Resident's family or legal representation immediately upon coming aware of the incident if it results in physical injury or distress to resident that could become potentially detrimental to the resident or notify the family or legal representative within 12 hours for other alleged abuse and neglect situations. The Home will also contact the family or legal representative when the investigation is complete and what action is taken."

Record review of the homes internal investigation notes and the electronic clinical record for Resident # 31 revealed no documented evidence identifying that the staff had notified the family of the incident related to alleged staff to resident abuse.

Staff Interview with the Director of Clinical Services and Education on April 21, 2015 confirmed the Substitute Decision Maker (SDM) for Resident # 31 was not contacted at the time of the incident. The Director stated that is the expectation of the home that Administration will contact the Resident's family or legal representative immediately upon becoming aware of the incident. [s. 97. (1) (a)]

WN #11: 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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to 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): A missing or unaccounted for controlled substance.

Record review of the Critical Incident (CI) Report 2878-000077-14 revealed the CI was not submitted until five days after the incident.

Record review of the Critical Incident (CI) Report 2878-000086-14 revealed the CI was not submitted until eight days after the incident.

Staff interview with the Administrator, on April 23, 2015 confirmed the critical incidents related to a missing or unaccounted for controlled substance should have been submitted within one business day. [s. 107. (3) 3.]

Issued on this 8th day of May, 2015

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

Original report signed by the inspector.