Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 29, 2016	2016_508137_0017	015930-16	Resident Quality Inspection

Licensee/Titulaire de permis

STEEVES & ROZEMA ENTERPRISES LIMITED
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

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

MARIAN MACDONALD (137), AMIE GIBBS-WARD (630), NANCY JOHNSON (538), SHERRI COOK (633)

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): August 16 - 19, 22 - 26 and 29-30, 2016

The following concurrent inspections were conducted during the Resident Quality Inspection (RQI):
Critical Incident Log # 008843-16 (CI 2878-000080-15) related to alleged staff to resident neglect;

**Critical Incident Log # 016837-16 (CI 2878-000081-15) related to falls prevention;
Critical Incident Log # 009885-16 (CI 2878-000084-15) related to alleged staff to resident neglect;
Critical Incident Log # 009994-16 (CI 2878-000006-16) related to missing controlled substances;
Critical Incident Log # 009941-16 (CI 2878-000013-16) related to falls prevention;
Critical Incident Log # 010845-16 (CI 2878-000014-16) related to falls prevention;
Critical Incident Log # 009931-16 (CI 2878-000015-16) related to falls prevention;
Critical Incident Log # 008237-16 (CI 2878-000019-16) related to falls prevention;
Critical Incident Log # 009709-16 (CI 23878-000021-16) related to skin and wound;
Critical Incident Log # 012882-16 (CI 2878-000024-16) related to alleged resident to staff abuse;
Critical Incident Log # 013173-16 (CI 2878-000025-16) related to alleged staff to resident neglect;
Critical Incident Log #' s 016299-16, 016309-16, 016476-16 and 016809-16 (CI 2878-000028-16, 2878-000029-16, 2878-000030-16 and 2878-000032-16) related to alleged resident to resident abuse;
Critical Incident Log # 012211-16 (CI 2878-000023-16) related to alleged resident to resident abuse;
Critical Incident Log # 017830-16 (CI 2878-000035-16) related to alleged resident to resident abuse;
Critical Incident Log # 022269-16 (CI 2878-000038-16) related to falls prevention;
Critical Incident Log # 010836-16 (CI 2878-000022-16) related to falls prevention;
Critical Incident Log # 026310-16 (CI 2878-000039-16) related to alleged staff to resident abuse;
Complaint Log # 016854-16 (IL-44774-LO, IL-44920-LO and CI 2878-000033-16) related to call bell response time;
Complaint Log #'s 010826-16 and 011259-16 (IL-44162-LO and IL-44216-LO) related to alleged neglect of a resident.**

During the course of the inspection, the inspector(s) spoke with Administrator, Manager Resident Care, Assistant Manager Resident Care, Business Manager, Director - Clinical Services and Education, Vice-President - Long Term Care (Corporate), Manager Life Enrichment, Manager Food Services, Ward Clerk, Resident Care Coordinator, Registered Dietitian, Resident Assessment Instrument (RAI) Manager, two Registered Nurses (RN), 11 Registered Practical Nurses (RPN), 24 Personal Support Workers (PSW), six Food Service Workers, two Housekeepers, one Life Enrichment Worker, one Restorative Care Aide, one Cook, one

Physiotherapy Assistant, one Maintenance Worker, 40 plus Residents and five Family Members.

The Inspectors also toured all resident neighbourhoods, common areas, medication storage area, observed dining service, care provision, resident/staff interactions, recreational programs, medication administration, reviewed residents' clinical records, relevant policies and procedures, staff education records and various meeting minutes.

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

Findings/Faits saillants :

1. The licensee failed to ensure that if there were locks on bedrooms, washrooms, toilet or shower rooms, the locks were to be designed and maintained so that they can be readily released from the outside in an emergency.

A review of the Family Council meeting minutes, of April 8, 2016, indicated a safety concern, related to locks on resident bathroom doors.
A response to the concern, on May 6, 2016, indicated some bathroom doors were equipped with locks and some have had them removed. A key was always to be readily available at each nursing station on each neighborhood should access be needed.

On August 27, 2016, at 0910 hours, Inspector # 137 and Director Clinical Services and Education # 137, conducted a tour on one identified Neighborhood. Both observed push button locks on resident bathroom doors that could not be readily released from the outside in an emergency and it was confirmed through demonstration.

A Registered Practical Nurse # 109 said Registered Practical Nurses (RPN) and housekeepers had narrow, metal keys (approximately 8.5 - 9 cm long) to release the lock mechanism. The keys were stored either on the RPN key ring, in a locked medication cart or on the housekeeper key ring.

Interviews were conducted with five Personal Support Workers # 118, # 149, # 150, # 151 and # 152, two Registered Practical Nurses # 109 and # 133, one housekeeper # 153 and one Registered Nurse # 122. Four of the nine staff members interviewed (44 per cent), were not aware that the resident bathroom doors locked or how to open the doors, in the event of an emergency, if a resident was locked inside the bathroom.

Inspector # 137 conducted a tour on all five neighborhoods. Four of the five (80 per cent) neighborhoods resident bathroom doors had locks that could not be readily released from the outside in an emergency.

The Director Clinical Services and Education # 137 and Administrator # 100 said the locks posed a potential risk of harm to residents and could not be readily released from the outside in an emergency.

The scope of this area of non-compliance was determined to be a level three, widespread, the severity was determined to be a level two, potential for actual harm and there has been no previous history of related non-compliance. [s. 9. (1) 3.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that the home was equipped with a resident-staff communication and response system that was properly calibrated so that the level of sound was audible to staff.

During a complaint and Critical Incident System (CIS) Inspection, incorporated into the Resident Quality Inspection (RQI), it was revealed that there was an alleged delay of staff responding to the communication and response system, for an identified resident.

On August 26, 2016 at 1225 hours, on an identified Neighborhood, Inspector # 137 asked Personal Support Worker (PSW) # 156 and Registered Practical Nurse (RPN) # 109 if call bells were audible in the dining room. Both said no. RPN # 109 said the call bell signal was to go to the RPN's phone, after approximately six rings.

Inspector # 137 tested some call bells to determine how long it took for the signal to go to the RPN's phone.
The call bell was activated in a resident's room, rang over 75 times, did not go to the RPN's phone and was not audible in the dining room.
The call bell was activated in a second resident's room, rang over five minutes, did not go to the RPN's phone and was not audible in the dining room.
The call bell was activated in a third resident's room and Inspector # 137 waited in the dining room to see how long it took for the signal to go to the RPN's phone. It took 11 minutes before the RPN received the signal, the phone was not equipped with call display so the RPN did not know which call bell was activated and the call bell was not audible in the dining room.
The call bell was activated at 1255:15 hours and was received on the RPN phone at 1306:15 hours.

During interviews with PSW # 152, # 157, # 158 and RPN # 109, Inspector # 137 asked if it was possible for a resident to wait 10 - 20 minutes for a call bell to be responded to, especially before the supper meal.
All responded yes. PSW # 152 said at that time two PSW's were doing baths/showers which takes 15-20 minutes each and call bells cannot be heard in the tub/shower room. The other two PSW's would be toileting/assisting residents, before the supper meal, and call bells cannot be heard in resident bedrooms/bathrooms, if the doors were closed.
Inspector # 137 entered an identified resident's room and closed the door. RPN # 109 activated a call bell in a room next door. The call bell was barely audible to the Inspector.

On August 26, 2016 at 1325 hours, on another identified Neighborhood, Inspector # 137 tested a call bell to determine how long it took for the signal to go to the RPN's phone.
The call bell was activated in an identified resident's room and it took six and a half minutes before the RPN # 117 received the signal on the phone.
The bell was activated at 1325:15 hours and was received on the RPN phone at 1331:45 hours.

During an interview, on August 26, 2016 at 1430 hours, the Manager Resident Care # 102 said that, during the internal investigation and interviews, it could not be confirmed that there was a delay, responding to the communication and response system, for an identified resident.

During an interview, on August 26, 2016, the Director Clinical Services and Education #

137 said the delay of the call bell response to the RPN phones was unacceptable and posed a risk to residents. A contract company would be in the home on Monday, August 29, 2016 to evaluate the existing resident-nurse communication and response system and provide quotes to replace the current system.

During an interview, on August 29, 2016 at 1550 hours, Inspector # 137 asked the Director Clinical Services and Education # 137 what immediate interventions were being put in place to mitigate risk to residents related to call bells not being audible to staff, in all resident neighborhoods, including dining rooms, tub/shower rooms and resident bedrooms/bathrooms, when doors were closed.
The Director Clinical Services and Education # 137 said Administrator # 101 had received quotes for three resident-nurse communication and response system options. One option would be selected and submitted to Corporate Office for approval.
A company was to visit the home on August 30, 2016, to determine if all call bell signals would be able to go to the RPN phone, if not responded to after three minutes.
On August 30, 2016 at 1600 hours, Inspector # 137 asked the Administrator # 100 to provide an update, via email, regarding the outcome of the identified company's visit..

The Director Clinical Services and Education # 137 said it was unacceptable that the call bells were not audible to staff, throughout the home, in dining rooms, tub/shower rooms and resident bedrooms/bathrooms when doors were closed, as well as the delay of the call bell response to the RPN phones and posed a risk to residents.

A Written Notification was previously issued on January 28, 2014 under Log # L-000021 -14 and Inspection # 2014_242171_0003, related to two call bells not working in residents' rooms and a Written Notification and Voluntary Plan of Correction was previously issued on April 13, 2015 under Log # L-001951-15 and Inspection # 2015_303563_0015, related to a resident-staff communication and response system was not available in the Snoezelen Room. [s. 17. (1) (g)]

The scope of this area of non-compliance was determined to be a level three, widespread, as it affected all five neighborhoods (100 per cent). The severity was a level three, actual risk and there was previously related non-compliance.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

During an interview, an identified resident said they had special dietary needs.
A review of the care plan revealed the identified resident was at high nutritional risk, had inadequate intake and required a modified diet texture.
A customized menu outline was provided.

Observations, during a lunch meal, revealed the resident was not provided the specialized menu items and was not offered a choice.

During an interview with Manager of Food Services (MFS) # 126 and Registered Dietitian (RD) # 127, it was reported that the identified resident required specialized menu items at meals and that it was the expectation that staff would offer the resident the specialized menu items that were specified in the plan of care, at each meal, as well as a meal choice.

This area of non-compliance was previously issued as a Voluntary Plan of Correction on April 13, 2015, under Log # L-001951-15 and Inspection # 2015_303563_0015 and a Written Notification with Compliance Order on October 31, 2014, under Log #' 005623-14 and 007309-14 and Inspection # 2014_303563_0049, which was complied with on December 2, 2014. [s. 6. (7)]

The scope of this issue was isolated. The severity was determined to be level two, with potential for actual harm.

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place related to responsive behaviours was complied with.

Review of Critical Incident Report indicated that resident # 075 exhibited responsive behaviours.

Clinical record review found that, during an identified period of time, resident # 075 had 17 documented incidents involving other residents. A progress note stated "BSO has started a DOS charting on resident # 075 to see why the resident may be having reactive behaviours."

During an interview with the BSO Team PSW # 141, PSW # 130 and RPN # 133, it was reported that resident # 075 started having more aggressive behaviours towards other residents for approximately one year. The resident had been assessed and followed by the BSO team due to responsive behaviours. The BSO Team reported that they relied heavily on the Behaviour Tracking Log (DOS) as part of the resident's ongoing behaviour assessments and these were to be completed by staff working in the neighbourhoods. RPN # 133 reported that the DOS charting was not always being completed fully for residents in the home and acknowledged the DOS charting was not completed fully for resident # 075. RPN # 133 reported they have tried to reinforce the importance of completing these assessments to the staff in the home.

Review of the DOS charting for resident #075 found it was initiated seven times, over an identified period of time, for a total of 49 days of behaviour tracking. Further review of this DOS charting found that the documentation was incomplete for 35 of the 49 days (71 per

cent).

The home's policy titled "RCM 10-05-00 Responsive Behaviour" with "Last Revision Date: June 7, 2016" stated "utilize screening tools and protocols to assist Team Members to understand the causes of a resident's responsive behaviours and to track the patterns of behaviours". This policy also stated "the ongoing tendency for the resident to exhibit a responsive behaviour is determined and documented". The home's "Behavioural Support Ontario Process Document" stated "BSO will complete a behaviour assessment".

On August 23, 2016, during an interview the Manager Resident Care (MRC) # 101 said the staff were to complete DOS charting on residents when there had been responsive behaviours, resulting in an altercation with another resident. The MRC # 101 also said it was the expectation in the home that the DOS charting be completed on each shift and acknowledged that they had been having problems with DOS charting not being done, as per the home's policy. MRC # 101 reported they were implementing a new process using a "RN Rounding Report" which included checking to ensure the DOS charting was completed each shift. [s. 8. (1) (b)]

2. Review of Critical Incident Report 2878-000023-16 indicated that resident # 072 had a history of responsive behaviours, including physically abusive behaviours towards staff and residents.

Clinical record review found that resident # 072 exhibited physically responsive behaviours towards resident # 071. Progress note by the BSO Team PSW # 141 stated "behavioural mapping has been started on resident # 072 today, due to recent incident, so please make sure it is completed".

On August 23, 2016, during an interview with the BSO Team PSW # 141, PSW # 130 and RPN # 133, it was reported that resident # 072 had a history of responsive behaviours which were directed towards staff and other residents. Resident # 072 had been assessed and followed by the BSO team due to responsive behaviours. RPN # 133 reported that the DOS charting was not always being completed fully for residents in the home and acknowledged the DOS charting was not completed fully for resident # 072.
Review of the DOS charting for resident # 072 was incomplete for 7 out of the 7 days (100 per cent).

The home's policy titled "RCM 10-05-00 Responsive Behaviour" with "Last Revision

Date: June 7, 2016" stated "utilize screening tools and protocols to assist Team Members to understand the causes of a resident's responsive behaviours and to track the patterns of behaviours". This policy also stated "the ongoing tendency for the resident to exhibit a responsive behaviour is determined and documented". The home's "Behavioural Support Ontario Process Document" stated "BSO will complete a behaviour assessment".

On August 23, 2016, during an interview the Manager Resident Care (MRC) # 101 said the staff were to complete DOS charting on residents when there had been responsive behaviours resulting in an altercation with another resident. The MRC # 101 also said it was the expectation in the home that the DOS charting be completed on each shift and acknowledged that they had been having problems with DOS charting not being done, as per the home's policy. MRC # 101 reported they were implementing a new process using a "RN Rounding Report" which included checking to ensure the DOS charting was completed each shift.

The scope of this issue was widespread. The severity of the issue was determined to be level two, with potential for actual harm. There was no previously related non-compliance, related to the responsive behaviours policy. [s. 8. (1) (b)]

3. The licensee has failed to ensure that the "Weights and Heights Policy Number FSM 10-10" was complied with.

Clinical record review of the 40 residents from the Stage 1 sample of the Resident Quality Inspection (RQI) on August 22, 2016, showed that 30 of 40 (75 per cent) residents did not have an annual height recorded.

Review of the "Weights and Heights Policy Number FSM 10-10" with "Last Revision Date: December 9, 2015" showed "each resident's height is measured in centimeters and recorded by the nursing team members upon admission and yearly thereafter in the resident's computerized chart".

During an interview on August 22, 2016, Resident Assessment Instrument (RAI) Manager # 138 acknowledged that annual heights were not measured and recorded for all residents.

During an interview on August 22, 2016, FSM # 126 and RD # 127 reported that it was the expectation in the home that each resident would have their height measured

annually, as per the policy. They acknowledged that they were aware that these were not being completed consistently in the home and were working on a process to improve the measurement of heights annually in the home.

The scope of this issue was widespread. The severity of this issue was determined to be level one with minimum risk. It was previously issued as a Voluntary Plan of Correction on April, 13 2015, under Log # L-001951-15 and Inspection # 2015_303563_0015. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, specifically related to responsive behaviours and heights, are complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred immediately reported the suspicion and the information upon which it was based to the Director.

A review of a Critical Incident System report indicated that resident # 073 exhibited physically responsive behaviours towards resident # 074, which caused injury.

The Manager of Resident Care # 101 said that the Registered Team Member (RTM), who worked when the incident occurred, did not follow the correct procedure in the home for reporting and, as a result, the MRC # 101 was not made aware of the incident, until five days later.
Review of the CIS indicated the after-hours pager was not contacted about the incident MRC # 101 reported that the Director was informed, through the critical incident system, eight days after the incident occurred.

MRC # 101 acknowledged that it was the expectation in the home that staff would notify management of potential resident to resident physical abuse immediately and that the home would immediately notify the Director.

2. The licensee failed to ensure that a person, who had reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A review of a Critical Incident System (CIS) report indicated there was a delay by staff responding to the communication and response system, for an identified resident.

Review of progress notes indicated a concern/complaint form was completed and submitted. Review of the CIS indicated the after-hours pager was not contacted about the incident. The CIS was not submitted until ten days after the incident occurred.

During an interview, on August 24, 2016, the Manager Resident Care # 101said that Director was not immediately informed, when suspicion that neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident had occurred. [s. 24. (1) 2.]

3. The licensee failed to ensure that a person, who had reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A review of a Critical Incident System (CIS) report indicated alleged neglect by staff, for not identifying a change in health status for resident # 064.
The MRC # 101 was made aware of the concerns, during a telephone conversation. The CIS was not submitted to the Director until six days after the concern was received.

During an interview, on August 24, 2016, the Manager Resident Care # 101 said that the Director was not immediately informed, when suspicion that neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident had occurred.

The scope of this area of non-compliance was determined to be a level three, widespread, as three of three (100 per cent) related CIS were not immediately reported to the Director, the severity was determined to be a level one and there was no previous history of related non-compliance. [s. 24. (1) 2.]

Additional Required Actions:

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

WN #6: 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:
12. Dental and oral status, including oral hygiene. 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 care set out in the plan of care was based on an assessment of the resident's dental and oral status, including oral hygiene.

During interviews, an identified resident said they had not received the required assistance from staff for oral care.

A record review of the Minimum Data Set (MDS), indicated that the resident required daily cleaning of teeth or dentures or daily mouth care, by resident or staff.

The admission Kardex for resident # 037 did not include oral care. The initial care plan stated that resident # 037 had upper dentures and lower teeth, and required set up help with oral care. The current care plan indicated the resident's preferred position for mouth care and did not include the natural lower teeth care needs and resident preferences.

Interview with Personal Support Worker's (PSW) # 135 and # 136 and Registered Practical Nurse (RPN) # 130 verified that the identified resident required assistance with oral care, which included upper denture cleaning/soaking, physical assistance and encouragement to brush the lower teeth daily.

Interview with Registered Nurse (RN) # 122 and the Resident Assessment Instrument (RAI) Manager # 138 verified that the registered staff should have updated the care plan and said that the current care plan did not reflect the resident's current needs and preferences related to oral care.

The scope of this area of non-compliance was isolated, the severity was determined to be a level two, minimal or potential for actual harm, and there was previous related non-

compliance. [s. 26. (3) 12.]

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

A record review of the twenty four hour care plan, for an identified resident, indicated the resident's preferred bedtime was at a specific time.The initial care plan did not include the resident's sleep patterns and preferences and the current care plan indicated a much earlier bedtime, compared to the twenty-four hour care plan.

During interviews, Registered Nurse # 122, Resident Care Coordinator # 121 and Manager Resident Care # 101, said that it was the expectation that the resident's sleep patterns and preferences, as indicated on the twenty four care plan, were included on the initial care plan so that staff were aware of residents sleep patterns and preferences.

The scope of this area of non-compliance is isolated, the severity was determined to be a level two, minimal or potential for actual harm, and there was previous related non-compliance. [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 care set out in the plan of care is based on an assessment of the resident's, specifically related to oral hygiene and sleep preferences, to be implemented voluntarily.

WN #7: 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,
(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, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated

An identified resident developed impaired skin integrity, which required interventions not available in the home.

A review of the progress notes and Treatment Administration Records (TARS), for an identified resident, indicated there was no documented evidence of a skin-wound note or a weekly skin-wound assessment completed for 14 days.

A review of the home’s policy, RCM 10-06-01 Skin and Wound Care Program, last revised May 28, 2016, indicates “Monitoring – A Pressure Ulcer Structured Progress Note – is completed by Registered Staff with each dressing change and wound measurements will be completed weekly. The ongoing weekly documentation will be completed when a resident is exhibiting altered skin integrity, breakdown, pressure ulcers, wounds and skin tears. The skin and treatment regimen will be recorded in the eTAR system with each dressing change. A care plan will be initiated or updated according to the status of the wound and treatment regimen”.

During an interview on August 23, 2016 at 1150 , the Manager Resident Care # 101 and Assistant Manager Resident Care # 140, said a skin wound note and weekly wound assessment had not been completed for resident # 062, as per the home's policy and wound care education, including documentation expectations, had been initiated for all registered staff to complete.

The scope of this area of non-compliance was isolated, the severity determined to be a level three, actual harm/risk and there was previously related history of non-compliance. [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, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: 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).
(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).
(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).
(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; O. Reg. 79/10, s. 51 (2).
(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).
(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; O. Reg. 79/10, s. 51 (2).
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) each resident who was incontinent received an assessment that included 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence; (b) each resident who was incontinent had 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 was implemented.

Review of Critical Incident System report indicated that resident # 002 had been incontinent and sustained a fall.
A review of the home's internal investigation records regarding this critical incident showed that resident # 002 was found to be incontinent of urine by a PSW and the PSW acknowledged, to the management of the home, that resident # 002 had not been changed or toileted.

Review of the clinical record for resident # 002 found the home did not complete a continence assessment at admission, did not reassess continence using a clinically appropriate assessment instrument when the resident's bladder continence declined and did not develop or implement an individualized plan of care for bladder continence based on an assessment.

During an interview on August 26, 2016, with RAI Manager # 138, it was reported that all residents were to have a continence assessment completed at admission and whenever there had been a change in continence identified. RAI Manager # 138 also reported that the plan of care for continence should be updated regularly to match the assessments and the coding in RAI MDS. RAI Manager # 138 acknowledged that resident # 002 did not have a continence assessment completed at admission, that there was not a reassessment completed using the "Continence Assessment Tool" when the coding for bladder continence changed from "continent" to "incontinent" of bladder. RAI Manager # 138 also acknowledged that the urinary continence plan of care for resident # 002 was not based on an assessment.

On August 26, 2016, MRC # 101 told Inspector # 630 that it was the expectation in the home that continence assessments would be done on admission including 4 day voiding record as well as reassessment when continence changes and that the plan of care would be correct and based on the assessment. The MRC acknowledged that these assessments had not been completed for resident # 002 and the plan of care was not based on the assessment.

The scope of this issue was isolated. The severity of this issue was determined to be

level two, with potential for actual harm. It was previously issued as a Written Notification on January 28, 2014, and February 6, 2014. [s. 51. (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 o ensure that (a) each resident who iss 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 requires, 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 was implemented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A clinical record review for resident # 065 indicated the resident expressed pain and required as needed analgesic administration on 13 occasions, during an identified period of time.

A review of the home's policy – RCM 10-04-01 Pain and Symptom Management Last revision date – October 28, 2015 indicted under Pain Assessment and Monitoring Procedure:
"The resident will be assessed or monitored for pain using the clinically appropriate pain assessment by a Registered Team Member when the resident's pain is not relieved by initial interventions.
Pain monitoring and assessment will be completed (at a minimum):
- Upon admission
- during the quarterly observation period for RAI-MDS
- on initiation of new routinely dosed analgesic or adjuvant therapy
Additionally, pain monitoring may be considered under the following conditions:
- A change in medical condition including medical procedures
- Upon resident reporting pain that is unrelieved by initial interventions
- Upon team members reporting pain being assessed/observed that is not relieved by initial interventions
- PRN pain medication in use for more than 72 hours and that pain remains uncontrolled
- Increase, decrease or discontinuation of routinely dosed PRN medications".

There was no documented evidence that a pain assessment had been completed on resident # 065, using a clinically appropriate assessment instrument specifically designed for this purpose.

During an interview, on August 24, 2016, the Assistant Manager Resident Care # 140 said a pain assessment had not been completed for resident # 065, on initiation of new routinely dosed analgesic or adjuvant therapy, as indicated in the home's policy.

The scope of this area of non-compliance was determined to be isolated, the severity was a level two, potential for actual harm and there was no previous history of related non-compliance. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #10: 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 :

The licensee has failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to these behaviours; and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A review of a Critical Incident System report indicated that resident # 073 exhibited physically responsive behaviours towards resident # 074, which caused injury.

During an interview on August 24, 2016, RPN # 125 said that staff were made aware of the triggers for responsive behaviours for residents through the plan of care. RPN # 125

also said that all altercations between residents were to be documented in the progress notes and then appropriate assessments started. RPN # 125 reported that resident # 073 did have responsive behaviours at times and the behaviour could change quickly. RPN # 125 further reported there had been a physical altercation between resident # 073 and # 074.

On August 23, 2016, during an interview with the BSO Team PSW # 141, PSW #1 30 and RPN # 133, it was reported that resident # 073 had not been referred or assessed by the BSO program and they had not heard of any concerns regarding responsive behaviours. They reported that they were to receive referrals from the staff in the neighbourhoods, when there had been an altercation between residents.
Clinical record review for resident # 073 found there was no documentation or assessment in the progress notes regarding the altercation with resident # 074. Review of the assessments completed for resident # 073 found no Behavioural Tracking (DOS) charting and no BSO assessments of responsive behaviour. Review of the plan of care found it included "Agitation/Resistive to treatment and/or care related to: Cognitive impairment" but did not identify triggers or interventions related to physical altercations with other residents when entering the resident's room.

On August 25, 2016, MRC # 101 told inspector # 630 that it was an expectation in the home that staff follow the Responsive Behaviour policy when there have been altercations between residents, as this directed them regarding documentation, assessments and reassessments of responsive behaviours. MRC # 101 reported the incident had been investigated on the same day the concerns were brought forward.

MRC # 101 said based on this investigation, it was determined that the responsive behaviours were not documented for resident # 073 and there were no re-assessments completed for resident #073. MRC # 101 said it was the expectation that staff would document the incident, do further assessments and that triggers for responsive behaviours that could lead to altercations would be identified.

The scope of this issue was isolated. The severity was determined to be level two, with potential for actual harm. It was previously issued as a Voluntary Plan of Correction on April 13, 2015, under Log # L-001951-15 and Inspection # 2015_303563_0015. [s. 53. (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 for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to these behaviours, and 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, to be implemented voluntarily.

WN #11: 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. (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 all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in abuse recognition and prevention.

On August 23, 2016, an interview with the Manager Resident Care # 101 verified that the home's Abuse education program included the Resident Bill of Rights and Elder Abuse booklets, Abuse quiz, in-service and a review of the home's Abuse policy ADMIN 08-05 Resident Abuse and Neglect, revised July 19, 2016.

Record review of the 2015 acknowledgement forms, completed by staff after reviewing the Resident Rights and Elder Abuse Booklets, verified that 70 of 205 (34 percent) direct care staff had not received the required training, an additional 45 (22 percent) direct care staff had been given the booklets and had not acknowledged them as completed.

Record review of the home's abuse policy ADMIN 08-05 Resident Abuse and Neglect, revised July 19, 2016 indicated that all team members would receive annual education on the abuse and neglect policy.

On August 24, 2016 the Manager Resident Care # 101 and Director of Clinical Services and Education # 137 agreed that all direct care staff did not receive the required annual abuse training in 2015.

The scope of this area of non-compliance is wide-spread, the severity was determined to be a level two, minimal or potential for actual harm and there was no previous related non-compliance. [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 o ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, annual training in abuse recognition and prevention, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when a written complaint was received, concerning the care of a resident or the operation of the long-term care home, the complaint was immediately forwarded to the Director.

On two identified occasions, the home received a written complaint related to alleged staff neglect towards resident # 064 and resident # 065.
The home provided email responses to the complainants but the complaints and the home's responses were not immediately forwarded to the Director.

On August 24, 2016, during interviews, the Manager Resident Care # 101 and Director Clinical Services and Education # 137 said the written complaints and the home's responses should have been immediately forwarded to the Director.

The scope of this area of non-compliance is isolated, the severity is determined to be a level one, minimal harm, and there is no previously related non-compliance. [s. 22. (1)]

Issued on this 19th day of October, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIAN MACDONALD (137), AMIE GIBBS-WARD (630), NANCY JOHNSON (538), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2016_508137_0017
Log No. / Registre no:	015930-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 29, 2016
Licensee / Titulaire de permis :	STEEVES & ROZEMA ENTERPRISES LIMITED 265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	WESTMOUNT GARDENS LONG TERM CARE HOME 590 Longworth Road, LONDON, ON, N6K-4X9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andrew Adamyk

To STEEVES & ROZEMA ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

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

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must take action to achieve compliance by ensuring any locks on bedrooms, washrooms, toilet or shower rooms are designed and maintained so they can be readily released from the outside in an emergency.

Grounds / Motifs :

1. The licensee failed to ensure that if there were locks on bedrooms, washrooms, toilet or shower rooms, the locks were to be designed and maintained so that they can be readily released from the outside in an emergency.

A review of the Family Council meeting minutes, of April 8, 2016, indicated a safety concern, related to locks on resident bathroom doors.
A response to the concern, on May 6, 2016, indicated some bathroom doors were equipped with locks and some have had them removed. A key was always to be readily available at each nursing station on each neighborhood should access be needed.

On August 27, 2016, at 0910 hours, Inspector # 137 and Director Clinical Services and Education # 137, conducted a tour on one identified Neighborhood. Both observed push button locks on resident bathroom doors that could not be readily released from the outside in an emergency and it was confirmed through demonstration.

A Registered Practical Nurse # 109 said Registered Practical Nurses (RPN) and housekeepers had narrow, metal keys (approximately 8.5 - 9 cm long) to release the lock mechanism. The keys were stored either on the RPN key ring, in a locked medication cart or on the housekeeper key ring.

Interviews were conducted with five Personal Support Workers # 118, # 149, # 150, # 151 and # 152, two Registered Practical Nurses # 109 and # 133, one housekeeper # 153 and one Registered Nurse # 122. Four of the nine staff members interviewed (44 per cent), were not aware that the resident bathroom doors locked or how to open the doors, in the event of an emergency, if a resident was locked inside the bathroom.

Inspector # 137 conducted a tour on all five neighborhoods. Four of the five (80 per cent) neighborhoods, resident bathroom doors had locks that could not be readily released from the outside in an emergency.

The Director Clinical Services and Education # 137 and Administrator # 100 said the locks posed a potential risk of harm to residents and could not be readily released from the outside in an emergency.

The scope of this area of non-compliance was determined to be a level three, widespread, the severity was determined to be a level two, potential for actual harm and there has been no previous history of related non-compliance.
(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee must take action to achieve compliance by ensuring the home is equipped with a resident-staff communication and response system that is properly calibrated so that the level of sound is audible to staff in every area accessible by residents, including all dining rooms, tub/shower rooms and resident bedrooms/bathrooms when doors are closed.

Grounds / Motifs :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was properly calibrated so that the level of sound was audible to staff.

During a complaint and Critical Incident System (CIS) Inspection, incorporated into the Resident Quality Inspection (RQI), it was revealed that there was an alleged delay of staff responding to the communication and response system, for an identified resident.

On August 26, 2016 at 1225 hours, on an identified Neighborhood, Inspector # 137 asked Personal Support Worker (PSW) # 156 and Registered Practical

Nurse (RPN) # 109 if call bells were audible in the dining room. Both said no. RPN # 109 said the call bell signal was to go to the RPN's phone, after approximately six rings.

Inspector # 137 tested some call bells to determine how long it took for the signal to go to the RPN's phone.
The call bell was activated in a resident's room, rang over 75 times, did not go to the RPN's phone and was not audible in the dining room.
The call bell was activated in a second resident's room, rang over five minutes, did not go to the RPN's phone and was not audible in the dining room.
The call bell was activated in a third resident's room and Inspector # 137 waited in the dining room to see how long it took for the signal to go to the RPN's phone. It took 11 minutes before the RPN received the signal, the phone was not equipped with call display so the RPN did not know which call bell was activated and the call bell was not audible in the dining room.
The call bell was activated at 1255:15 hours and was received on the RPN phone at 1306:15 hours.

During interviews with PSW # 152, # 157, # 158 and RPN # 109, Inspector # 137 asked if it was possible for a resident to wait 10 - 20 minutes for a call bell to be responded to, especially before the supper meal.
All responded yes. PSW # 152 said at that time two PSW's were doing baths/showers which takes 15-20 minutes each and call bells cannot be heard in the tub/shower room.
The other two PSW's would be toileting/assisting residents, before the supper meal, and call bells cannot be heard in resident bedrooms/bathrooms, if the doors were closed.
Inspector # 137 entered an identified resident's room and closed the door. RPN # 109 activated a call bell in a room next door. The call bell was barely audible to the Inspector.

On August 26, 2016 at 1325 hours, on another identified Neighborhood, Inspector # 137 tested a call bell to determine how long it took for the signal to go to the RPN's phone.
The call bell was activated in an identified resident's room and it took six and a half minutes before the RPN # 117 received the signal on the phone.
The bell was activated at 1325:15 hours and was received on the RPN phone at 1331:45 hours.

During an interview, on August 26, 2016 at 1430 hours, the Manager Resident Care # 102 said that, during the internal investigation and interviews, it could not be confirmed that there was a delay, in staff responding to the communication and response system, for an identified resident.

During an interview, on August 26, 2016, the Director Clinical Services and Education # 137 said the delay of the call bell response to the RPN phones was unacceptable and posed a risk to residents. A contract company would be in the home on Monday, August 29, 2016 to evaluate the existing resident-nurse communication and response system and provide quotes to replace the current system.

During an interview, on August 29, 2016 at 1550 hours, Inspector # 137 asked the Director Clinical Services and Education # 137 what immediate interventions were being put in place to mitigate risk to residents related to call bells not being audible to staff, in all resident neighborhoods, including dining rooms, tub/shower rooms and resident bedrooms/bathrooms, when doors were closed. The Director Clinical Services and Education # 137 said Administrator # 101 had received quotes for three resident-nurse communication and response system options. One option would be selected and submitted to Corporate Office for approval.
A company was to visit the home on August 30, 2016, to determine if all call bell signals would be able to go to the RPN phone, if not responded to after three minutes.
On August 30, 2016 at 1600 hours, Inspector # 137 asked the Administrator # 100 to provide an update, via email, regarding the results of the identified company's visit..

The Director Clinical Services and Education # 137 said it was unacceptable that the call bells were not audible to staff, throughout the home, in dining rooms, tub/shower rooms and resident bedrooms/bathroom when doors were closed, as well as the delay of the call bell response to the RPN phones and posed a risk to residents.

A Written Notification was previously issued on January 28, 2014 under Log # L-000021-14 and Inspection # 2014_242171_0003, related to two call bells not working in residents' rooms and a Written Notification and Voluntary Plan of Correction was previously issued on April 13, 2015 under Log # L-001951-15 and Inspection # 2015_303563_0015, related to a resident-staff communication

and response system was not available in the Snoezelen Room.

The scope of this area of non-compliance was determined to be a level three, widespread, as it affected all five neighborhoods (100 per cent). The severity was a level three, actual risk and there was previously related non-compliance.

(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
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

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD

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