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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 10, 2015	2015_396103_0053	O-002649-15	Resident Quality Inspection

Licensee/Titulaire de permis

COUNTY OF PRINCE EDWARD
603 Highway 49 R R 2 PICTON ON K0K 2T0

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

H.J. MCFARLAND MEMORIAL HOME
R.R. #2, 603 HIGHWAY 49 HALLOWELL TOWNSHIP PICTON ON K0K 2T0

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

DARLENE MURPHY (103), AMBER MOASE (541), HEATH HEFFERNAN (622), SUSAN DONNAN (531)

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): September 28-30, October 1- 2, October 5-9, and October 13, 2015.

The following logs were also included in this inspection: O-001849-15, O-001946-15, O-002295-15, O-001557-15, O-002501-15, O-002509-15 and O-002567-15.

During the course of the inspection, the inspector(s) spoke with Residents, Resident and Family Council representatives, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Physiotherapist (PT), the Physiotherapy assistant, Laundry aides, Housekeeping aides, Maintenance worker, Environmental Manager, Resident Services Manager, Receptionist, Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspectors conducted a full walking tour of the home, made dining room and resident care observations, observed medication administration and practices, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident and family council minutes, applicable home policies, the home's documented complaint record, the home's staffing schedules for the nursing department and the home's staffing plan.

The following Inspection Protocols were used during this inspection:

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

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (2)	CO #001	2015_347197_0024	531

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).

Findings/Faits saillants :

1. The licensee has 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.

On September 29, 2015 on or about 1400hr, Inspectors #541 and #103 observed resident #042 in a wheelchair in the main hallway outside of the family dining room. The resident was observed to have a device applied in such a way that it prevented the resident from being able to remove the device. Resident #042 was interviewed and confirmed he/she was unable to remove the device.

Inspector #103 spoke with RN #105 who stated the resident had just began using this device and that she had applied it this morning. The RN was asked to come and observe the resident and she noted the device was applied in such a way the resident would not be able to remove it on their own. RN #105 stated she had not applied the device in that manner and suggested one of the co-residents may have altered the device. RN #105 stated she would ensure staff were educated on how to properly apply the device.

On October 1, 2015, Inspectors #103 and #541 both observed resident #042 being pushed in the main hallway of the nursing home by a PSW. The resident was observed to be wearing the same device and it was applied in such a manner that the resident could not remove it on their own. The resident was transported to the main doorway of the home where he/she was left.

Inspector #103 asked the DOC to come and observe Resident #042. The DOC noted the application of the device and stated she had just seen a PSW take this resident out of the

tub room and bring them downstairs. The DOC was informed of the previous incident and the discussion that had taken place with RN #105. The DOC acknowledged the device was applied in a manner which would be considered a restraint. She concluded the staff member must have inappropriately applied it after the resident bath.

RPN #106 was interviewed and stated she had been working days all week and confirmed she had been giving shift report to the oncoming staff for the evening shift. The RPN was asked what information was being forwarded to staff during this report in regards to resident #042's newly acquired device. The RPN stated there was no information relayed to staff in regards to this and stated the application of this device was common sense.

Resident #042's care plan was reviewed and indicated a specified diagnosis.

The care plan failed to indicate the resident had this device and did not provide any direction to staff in regards to when or how to apply, remove it. [s. 6. (1) (c)]

2. Resident #020 had a specified diagnosis. The resident progress notes were reviewed from July 1, 2015 to date of this inspection. On a specified date, resident #020 fell and sustained an injury. According to staff, the resident was independent with transfers at the time of this fall.

Eight days later, the progress notes indicated the resident was attempting to unsafely self transfer. The following day, the staff documented the resident was assisted by a co-resident to transfer, but a fall was avoided. On a specified date, the Physiotherapist (PT) assessed the resident as high risk for falls and stated staff would be advised to use one staff to assist the resident to and from the toilet and bed, and that 2 staff could assist the resident to and from the dining room.

Four days after the PT assessment was completed, the progress notes indicated the resident was taken to a lounge and left there unattended to listen to music. The resident fell again and sustained a second injury. The post fall notes indicated the resident was wearing inappropriate foot wear.

RN #119 was interviewed and had been working at the time of this second fall. The RN indicated the PSW staff had left resident #020 to answer call bells and found the resident on the floor in the lounge when they returned. The RN was asked to comment on her documentation that indicated the resident was wearing inappropriate foot wear. The RN

stated the resident had slippers on with slippery bottoms and stated she felt it would be unusual for staff to walk the resident in this type of footwear but thought perhaps the resident did not have appropriate footwear to be used. The RN stated staff believed the resident fell because he/she attempted to stand on their own and slipped.

The resident care plan in place at the time of this second fall, failed to identify the resident as a high risk for falls. It did not include interventions to address the previously documented instances whereby the resident had attempted to self transfer following the fall that resulted in the first fractured hip. The care plan also failed to identify common safety risks such as ambulating only when appropriate foot wear was in place. [s. 6. (1) (c)]

3. Resident #020's most recent Minimum Data Set (MDS) assessment indicated resident requires total assistance with one to two person assist for dressing, bathing, transferring, toileting and personal hygiene. ADL RAP completed August 1, 2015 indicated resident requires extensive assistance with ADL tasks caused by progression of cognitive impairment and recent fall resulting in injury.

During an interview, PSWs #109 and #130 stated that resident #020 required total assistance with transfers. PSWs #109 and #130 stated the resident cannot weight bear, needs staff assistance to dress and uses a mechanical lift for transfers. PSW #130 stated the resident can eat independently with staff encouragement.

Physiotherapist #129 stated during an interview with inspector that Resident #020 is not able to weight bear and requires total assistance with bathing, dressing, toileting and transfers.

Resident #020's current plan of care effective August 11, 2015 indicated the following:

Dressing: Provide constant supervision and assistance, report any decrease in ability to dress self in a clean and appropriate manner.
Transfers: Resident can weight bear and transfers with 2 staff at all times.
Toileting: Goal for resident is to maintain ability to toilet self safely. Staff to provide some guidance and direction in locating washrooms related to cognitive impairment and periods of confusion.
Bathing: One person physical assist while bathing

The plan of care for resident #020 does not set out clear direction to staff in that it does

not reflect the residents current care needs. [s. 6. (1) (c)]

4. PSWs #120, #111 and #109 were interviewed to determine how they know a resident's level of mobility, any restraints that are to be applied or any other pertinent care needs. All three of the PSW's stated the information was previously recorded in the resident room inside their closets and highlighted those details. All stated, they found this information helpful and it was convenient. All indicated these were no longer either available or accurate. Resident #020's closet was checked and did have an outdated logo posted that indicated the resident could transfer with minimal assistance. PSW #109 stated she had worked in the home for several years, but stated she does not always work in the same area of the home and it can be difficult to keep up with changes. Another PSW stated if there was a seat belt on the resident chair, she would latch it and try to find out later if the resident had an order for the restraint. PSW staff indicated it is especially difficult for newly hired staff. PSW #128 is a newly hired worker and stated it is difficult to know the resident's care needs without asking co-workers. [s. 6. (1) (c)]

5. Resident #044 was observed sitting in the common area at 0900 hours and observations were made until 1325hr when the resident was returned to bed. The resident was not toileted during this observation time.

Resident #044's care plan in effect at the time of this inspection indicated:
resident is toileted A.C., P.C., A.M. and H.S; wears a medium brief.
Under Urinary Incontinence; INCONTINENT PROGRAM: Toilet ac, pc meals and qhs.

PSW staff were interviewed and indicated the resident is no longer toileted. The care plan fails to provide clear direction to staff.(622) [s. 6. (1) (c)]

6. 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.

The following findings relate to Log #O-002567-15:

On October 6, 2015, this inspector made observations of resident's #026 and #049 in regards to their toileting routines.

Resident #026 was observed from 0955hr until 1355hr and was not toileted during that time.

The resident's care plan in place at the time of this inspection was reviewed and indicated under Toileting:
-staff supervision and physical assistance of two staff for safety ie. adjust clothing, wash hands, pericare and application of product; resident should not be left alone to toilet for safety reasons.
Under ADL program: resident is participating in a Prompted voiding program in an attempt to improve level of incontinence.
Resident #026's kardex was also reviewed and indicated:
Approach resident at scheduled prompted voiding time ie: 0700, 0900, 1100, 1300. (15 minutes before or after assignment time are acceptable).

PSW staff were interviewed and stated this resident was not toileted in accordance with the plan of care.

Resident #049 was observed from 0955hr to 1355hr and the resident was not toileted during this time.

The resident's current care plan dated 09/02/2015, indicated under Incontinence:
Toilet routinely when gets up and before and after meals.
The resident Kardex for toileting was reviewed and indicated:
Approach - resident at scheduled prompted voiding time ie: 0700, 0900, 1100, 1300. (15 minutes before or after assignment time are acceptable).
Encourage resident to ask for toileting assistance, as needed.
Provide resident assistance with toileting
TOILETING - One person constant supervision and phys assist for safety ie. adjust clothing / wash hands / pericare.

PSW staff were interviewed and stated the resident was not toileted according to the plan of care. [s. 6. (7)]

7. On August 19, 2015, resident #052 was observed by this inspector to be self transferring into a chair by the window. The resident was observed to be very unsteady and was seen partially climbing over a wheelchair which was positioned directly in front of this chair. RPN #133 was asked to assist with the resident and the physiotherapist aide #134 went to find the PSW who was assigned to the resident. According to the PSW, she had just left resident #052 in his/her bed a short time ago. RPN #133 stated the battery for the bed alarm must be dead as it had not alarmed. Upon examination of the bed alarm, RPN #133 found the battery had been put in backwards. The RPN

properly inserted the battery and the bed alarm was then functioning.

RPN #133 was asked to explain the process for ensuring bed and chair alarms are in good working order. She stated she did not think there was an actual process and that if a PSW happened to find an alarm not working, it would be reported to her and she would locate a new battery. The RPN stated the bed alarm was an important fall prevention measure for this resident because resident #052 had recently sustained an injury and was known to unsafely transfer independently.

RN #119 was interviewed and stated the home does not currently have a process for checking to see if bed/chair alarms are working, but stated she believed RN #115 was looking into getting something in place. [s. 6. (7)]

8. During a review of resident #025's progress notes, this inspector noted the resident had sustained a fall on an identified date which resulted in an injury. RN #115 had documented the resident's bed alarm was not in working order.

The RN was interviewed and stated she couldn't recall if the battery needed changing, but confirmed the bed alarm was not functioning at the time of the fall and did not sound at the time of the fall. This RN indicated this resident has had many serious falls and confirmed the bed alarm was an important fall prevention measure to alert staff when the resident was attempting to self transfer. The RN was asked who is responsible for checking the functionality of the chair/bed alarms and stated the home does not have a process to her knowledge in regards to checking the chair/bed alarms at this time.

The DOC was interviewed and stated it would be her expectation, that staff would ensure all fall prevention measures were in good working order at the beginning of every shift.

Approximately one month later, staff documented the resident fell because the resident had undone the seat belt. Staff documented to monitor frequently as resident was unbuckling the belt. The following day, the resident fell again and sustained another injury. Staff documented the resident unbuckled the lap belt and was walking unassisted with poor balance. The staff further documented to consider an order for a table top or lap belt to buckle at the back. RN #105 was interviewed in regards to these falls and indicated resident #025 had a front latching seat belt at the time of those falls. The RN stated the resident is currently in a rear latching lap belt and could not undo it. The staff member was unable to explain why a rear latching lap belt had not been in place at the time of the two falls as indicated in the care plan.

The resident's care plan in place at the time of these falls was reviewed and indicated the following:

Use of an external device for prevention of injury to self characterized by high risk for injury/falls. Under Interventions, the care plan stated: use safety devices, rear closure seat belt when in wheelchair.
Staff failed to ensure the care set out in the plan of care was provided as specified in the plan. [s. 6. (7)]

9. In regards to Log #O-002295-15:

Resident #038 fell and sustained an injury on an identified date. The Physiotherapist (PT) was interviewed in regards to the therapy this resident was receiving post injury. The PT stated he sees the resident twice weekly for balance and strength training and the PT aide sees the resident four times each week. The PT further stated the resident has regained much of their mobility, however the resident's cognitive status makes it such that his/her decisions are not always good. The PT stated the resident may forget to take the walker with him/her and would put themself at risk for subsequent falls.

The PT stated he had recently met with the resident's family and they were requesting staff walk the resident with his/her walker to and from meals to maintain as much mobility as possible.

This inspector stated she had not seen nursing staff walking the resident to or from any of the meals observed during the RQI. The PT agreed nursing staff are not doing that on a regular basis, but agreed that it is a part of the resident plan of care and is important to maintain the resident's mobility.

This inspector noted on the dashboard of the electronic charting system, an entry with a specified date date which indicated resident #038 was to be walked to and from meals and all activities. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 8 (3) whereby at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

H.J. McFarland is an 84 bed home. In accordance with O. Reg. 79/10 s. 45 (1) 2., a home with a licensed bed capacity of more than 64 beds and fewer than 129 beds have exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as follows:

i. in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used, and

ii. in the case of an emergency where the back-up plan fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,

-the Director of Nursing and Personal Care or a registered nurse who is both an

employee of the licensee and a member of the regular nursing staff is available by telephone, and

-a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

In accordance with O. Reg. 79/10, s. 45 (2), "emergency" is defined as an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

This inspector reviewed the registered nursing schedule for the months of June, July, August and September 2015. The following shifts were identified as not having a registered nurse on duty and present in the home that is a member of the regular nursing staff:

July 17, 2015, night shift; The home utilized an agency RPN to replace the shift. There was no RN in the building during the night shift.

July 24, 25 and 26, 2015, night shifts; the home utilized an agency RN. The absence of the regularly scheduled RN for these shifts did not meet the allowable exceptions.

September 25, 2015, night shift from 0200-0700 hr; the home utilized an agency RPN for this shift; there was no RN in the building during this time. The absence of the regularly scheduled RN did not meet the definition of emergency.

The DOC was interviewed and stated she was unaware of the regulations or allowable exceptions to ensure an RN was on duty and present in the home at all times. [s. 8. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure staff apply the physical device in accordance with any manufacturer's instructions.

Resident #038 sustained a fall on an identified date and sustained an injury. On October 7, 2015, resident #038 was observed to be seated in a wheelchair in the area outside of the second floor elevator. The resident was observed to have a front closing lap belt in place and it was observed to be loose such that it could be pulled away from the resident's abdomen four to five inches. The inspector asked RPN #133 to assess the current placement of the lap belt. RPN #133 stated the lap belt was too loose and with some difficulty, adjusted the belt to a proper fit.

Resident #025 was assessed as high risk for falls and according to staff, the resident had sustained many falls. The resident's progress notes were reviewed and indicated the resident sustained a fall on an identified date. The notes stated the resident was found on the floor still buckled into the wheelchair and further indicated the resident lap belt had

been applied too loosely. Registered staff were interviewed and were able to confirm the details of the documented progress note. [s. 110. (1) 1.]

2. The licensee has failed to ensure staff only apply the physical device that has been ordered or approved by a physician or a registered nurse in the extended class.

Resident #025's health care record was reviewed and a physician order and a consent for a rear latching lap belt was found dated April 30, 2015. The resident progress notes were reviewed from July 15, 2015 to date of this inspection. On an identified date, staff documented the resident fell and the resident had undone the seat belt. Staff documented to monitor frequently as resident was unbuckling the belt. The following day, the resident fell again and sustained an injury. Staff documented the resident unbuckled the lap belt and was walking unassisted with poor balance. The staff further documented to consider an order for a table top or lap belt to buckle at the back. RN #105 was interviewed in regards to this fall and indicated resident #025 was currently in a rear latching lap belt and could not undo it. The staff member was unable to explain why a rear latching lap belt had not been in place at the time of the two falls despite the physician's order since April 30, 2015.

Resident #020 was observed in a tilt wheelchair with a front latching seat belt and a tray in place. The resident's health care record was reviewed and the physician had ordered a lap belt (buckle in the back), table top and tilt chair on a specified date. On the same date, the SDM had signed a consent for the same restraints.

Staff were interviewed and stated resident #020 has never had a rear latching lap belt and were unaware of the physicians order or the SDM's consent for the same.

Resident #052 fell and sustained an injury on a specified date. The resident health care record was reviewed in regards to restraints ordered for fall prevention. The resident was observed to be seated in a wheelchair with a rear latching seat belt. When staff were interviewed, they stated the rear latching belt was in place as the resident had previously fallen with injuries and was able to undo a front latching lap belt. Staff indicated the rear latching belt was a means of ensuring the resident did not unsafely transfer on his/her own and that the resident was unable to remove the rear latching belt, therefore making it a restraint for resident #052. The physician orders for this resident was reviewed from January 2015 to date of this inspection. A physician order was not found for the rear latching lap belt restraint or any form of restraint. The resident's SDM had signed a consent for a lap belt, tabletop and tilt chair on August 17, 2015. [s. 110. (2) 1.]

3. As discussed in WN #1, staff applied resident #042's device in a manner which restrained the resident. There were no physician's orders in place in regards to a physical restraint for resident #042 and it put the resident at risk of harm due to his/her inability to remove the device. [s. 110. (2) 1.]

4. The licensee has failed to ensure the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

On October 7, 2015 at 0940hr, this inspector had observed a loosely fitted seat belt for resident #038 and asked RPN #133 to reasesss the restraint. The restraint monitoring book was reviewed following the RPN's adjustment of the lap belt and this inspector found that all second floor restraints that were included in the restraint monitoring book had been signed off by the RPN at 0930hr for the day shift.

RPN #133 was interviewed in regards to the monitoring process in place for resident restraints. According to this staff member, each resident that has a restraint in place will have a restraint monitoring sheet that indicates the type of restraint in place. She further stated, registered staff must sign off on these sheets every shift. The RPN indicated it doesn't matter what time the sheets are signed off, but they must be signed every shift. The RPN indicated signing off indicates you are aware of the restraint ordered for the specific resident and that it is properly in place.

On October 6, 2015, RPN #131 was interviewed in regards to the resident restraints currently in place for resident #020 and stated this resident uses a front closing lap belt and a tray. The RPN stated the PSWs and the registered staff ensure the restraints are applied as ordered. Additionally, the RPN stated the registered staff sign off on a restraint monitoring sheet every shift to indicate the restraints are properly applied. The RPN checked for the monitoring sheet for resident #020, and stated the resident did not have one. According to the RPN, the night staff ensure new restraint forms are prepared for the beginning of each month and that she would need to start one for resident #020.

Resident #052 was also found to have no restraint monitoring sheet as of October 6, 2015.

Restraint monitoring sheets for resident #020 and #052 had not been completed from October 1 to October 6, 2015 or noted to be absent until such time the inspector

interviewed staff.

The DOC was interviewed and indicated the restraint monitoring sheets are to accurately reflect the ordered restraints for the resident. She also indicated the registered staff are to sign off every shift and this signature indicates they have monitored the resident while restrained and the restraint is properly applied. [s. 110. (2) 3.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to to comply with the LTCHA 2007, c. 8, s. 15 (2) whereby the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the course of the inspection and constitute potential risk related to resident safety:

Tub/shower rooms:
-second floor tub room by the elevators it was noted that the lower 6"x 4' ceramic tile along south wall is heavily scarred, deeply gouged with sharp rough edges exposing concrete.
-second floor tub/shower room, the shower area was noted to have a floor seam in front

of the shower which was detached x 12 inches such that water could seep from the drain through the open seam and would cover the floor with water.
-Willow Wing tub room: was observed with the same water drainage issue as indicated above,
-the left lower shower wall has 5-6 ceramic tiles that are missing, exposing the wall board that has been water damaged, black in colour and splintered leaving a jagged edge.
-the same tub room was observed to have a large water stain and the drywall tape was observed as being detached along the ceiling above the entire length of the tub.
-large hole 2"x 8" on the ceiling above the tub where drywall is missing and caused by the mechanical chair lift for the tub.

First floor main dining/activity room- the parquet flooring was noted to have a worn, finish and was splintered.

Family dining room on the first floor, the flooring and furniture were observed to be heavily chipped, worn and discoloured.

Bedside furnishings in Resident rooms # 106, 136, 134, 170, 160 were observed to be worn, chipped and splintered.

Willow wing:
-5' x2 inch tear observed in the resident dining room floor covered with aged and damaged tape.
-ceiling between the Willow Wing television and dining room has approx 3'x 5-6" area has been plastered heavily and remains unfinished and water stained.
-alcove ceiling in the Willow Wing dining room along south wall windows has numerous water stains.

-flooring in resident's #06, 037, 012 and 014 bathroom in front of toilets noted to have 3' x 1" area of flooring noted as being detached exposing black stained concrete beneath, and whitish stains on the surface.
-blackened colour beneath silicone seal surrounding toilet bowls
-resident #06 shared bathroom- the sink drain was observed to be corroded.
-Willow Wing ceiling directly across from the HVAC vents observed with black soot-like stains across the ceiling.
-vents in the Willow Wing tub/shower room, the north wall in the dining room, and the resident common bathroom off the dining room were observed with heavy dust like substance covering the vents.

-Willow Wing kitchenette cupboards are heavily scarred, gouged and lower cupboard door missing with contents that have sharp edges.
-cupboard doors are soiled, worn and no longer will close.
-Activity cupboard in the Willow Wing kitchenette observed with the entire back detached and multiple nails in the detached board
-Willow Wing wooden floor trim is scarred, worn/discoloured with damaged jagged corners.

PSW's #107 and #101 were interviewed and confirmed the damaged ceiling tile above the Willow Wing tub/shower room, flooring, dining room flooring heaved and taped , plaster in dining room thick and water stained have been damaged for approximately two to three years.

The housekeeping aide #113 was interviewed and confirmed that she and #140 from laundry are responsible to manage drywall repair and painting one day per week. Housekeeping aide #113 confirmed that the drywall repairs are not being completed weekly due to staff shortages in laundry and housekeeping over the summer months. Housekeeping aide #113 confirmed that they have not had any formal training in drywall.

The maintenance worker and the Environmental manager were interviewed and confirmed that the floor and ceiling damage in the Willow Wing dining area above resident tables has been an ongoing issue for the past two to three years due to the dining room windows that are damaged and causing water leakage when it rains. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, 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 comply with LTCH Act 2007 s. 24 (1) whereby the Director was not immediately notified of a resident to resident suspected abuse.

The following findings relate to Log # O-002509-15:

On an identified date, a critical incident was submitted to the MOHLTC to report an alleged incident of resident to resident physical abuse..

During an interview with RN #118, she indicated she was the charge nurse at the time of this incident and therefore was the representative of the licensee at that time. The RN confirmed that the Director was not immediately notified of the suspected physical abuse.

The DOC was interviewed and confirmed this incident occurred on a specified date and the Director was notified of the incident for the first time three days after the incident. [s. 24. (1)]

2. The following findings relate to Log #O-001946-15:

On a specified date, resident #048 reported an allegation of staff to resident abuse. The Administrator was interviewed and stated the resident reported it to the RN working the next day. The resident and staff members were interviewed by the Administrator and the Resident Services Manager that morning. The Administrator stated following the investigation, the home had no findings against either staff members.

The Administrator stated she then received a written letter of complaint from resident #048's family in regards to the allegation. According to the Administrator, it was at that time it was decided to send a critical incident report to the MOHLTC to report the alleged staff to resident abuse. The report was submitted for the first time fifteen days after the alleged incident. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a person who has reasonable grounds to suspect the abuse of a resident by anyone shall immediately report the suspicion and 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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure there is a written staffing plan that provides for the following:

-a staffing mix that is consistent with the residents' assessed care and safety needs and that meets the requirements set out in the Act and Regulations,
-set out the organization and scheduling of staff shifts,
-promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident,
-include a back up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work, and
-be evaluated and updated at least annually in accordance with evidence based practices and if there are none, in accordance with prevailing practices.

The Director of Care (DOC) was interviewed and asked to provide this inspector with a copy of the staffing plan. The DOC provided the inspector with an outline of the registered and non registered staff that are scheduled for each of the three shifts. According to the DOC, the home does have a call in process whereby shifts are attempted to be filled and overtime is authorized. The DOC stated the home does not have anything additional in writing including a written back up plan to address situations whereby staff cannot come to work. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a written staffing plan is developed that meets the legislated requirements outlined in the non compliance, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

During this inspection, this inspector observed on two separate occasions, resident #054 being transferred onto the tub lift chair with the assist of only one staff member. PSW staff were interviewed and stated in some instances, residents who are either independent in their mobility or those who require minimal assistance with transfers are assisted in and out of the tub using the lift chair with only one staff member present. Many of the staff interviewed were aware that all mechanical lifts require two staff when being operated.

Additionally the inspector noted the safety belt that is supplied as a safety device for the tub lift is not utilized. According to the staff interviewed, they stated they have been told they cannot use the safety belt as it would be considered a restraint.

The home's lift and transfer policy titled, "Lifts and Transfers: Mechanical lift: Arjo Tub lift" was reviewed and indicates under Procedure:
-two staff are required to use this lift,
-the lift is used to transfer residents into the Arjo Tub,
-position the resident onto the lift...attach the safety belt. [s. 36.]

2. Resident #025's health care record was reviewed and this inspector noted a progress note entered by the physiotherapist. The note indicated that the resident had been fitted with a very low wheelchair in order to enable this resident to self propel. The progress notes indicated due to the resident's cognition and the height of the chair, that foot pedals should be used to avoid injury to the resident while being transported by staff. This inspector noted the resident's foot pedals were available in the resident room, however the pedals were not observed to be used throughout the inspection period.

Staff were observed directing the resident to lift his/her feet while they transported the resident through the hallways. The resident was observed at times to hold his/her feet outward for a short time and then both feet were observed to drag on the floor either in front of the wheelchair or slightly under the seat of the wheelchair.

The physiotherapist was interviewed and agreed this was an unsafe practice due to the resident's cognitive impairment and could lead to resident injury. [s. 36.]

3. On October 6, 2015, this inspector observed a PSW to assist resident #038 from their dining room chair into the wheelchair. The PSW was observed moving the wheelchair into position and applied only the left brake. The resident stood independently and was observed to land hard into the wheelchair. The wheelchair rolled back and to the right as this brake was not engaged.

Registered staff were interviewed and stated both brakes should be engaged during the transfer to prevent the wheelchair from tipping over or rolling backward and potentially injuring the resident. [s. 36.]

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 two staff are utilized for all residents that require mechanical lifts, including the tub lift, all staff apply both wheelchair brakes prior to transferring residents and staff utilize foot pedals when transporting residents in their wheelchairs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure proper techniques were provided to assist residents with eating, including positioning of residents who require assistance.

On October 6 during the lunch meal, resident #020 was observed being brought into the main floor dining room in a wheelchair by a PSW. The resident's wheelchair had an attached tray in place and the resident was observed to be slouched down in the chair. The resident tray remained on throughout the meal service and at no time did staff attempt to reposition the resident. Resident #020 remained slouched in the wheelchair until the resident was removed from the dining room at approximately 1250hr without being repositioned.

PSW staff were interviewed and indicated resident #020 would require total assistance from staff for repositioning in the wheelchair. [s. 73. (1) 10.]

2. The licensee has failed to comply with O. Reg. 79/10, s 73 (1) 11 whereby staff who were assisting residents to eat were not appropriately seated.

During the course of the inspection, the following dining observations were made in the Willow Wing Dining area:

On October 5, 2015, PSW's #128 and #126 stood while providing resident's #005 and #046 with feeding assistance during the entire breakfast meal.

During the evening meal, PSW #107 was observed standing while feeding residents #005, #047 and #046 their supper meal, and PSW #125 was noted standing while providing feeding assistance to resident #036.

During an interview with PSWs #107 and #125, both indicated that staff are to be seated while feeding residents. Both staff indicated this is difficult when there are only two staff available to provide feeding assistance and monitor others such as resident #036 who becomes distracted and wanders during the meal. PSWs #126 and #128 indicated that the staff previously had feeding stools on the home unit, but these have been removed and are now used for staff assisting residents in the main dining room.

On October 8, 2015 during an interview with Dietitian #136, she confirmed that staff are expected to provide dining assistance. [s. 73. (1) 11.]

3. The licensee has failed to comply with O. Reg. 79/10, s. 73 (2) whereby no person simultaneously assists more than two residents who need total assistance with eating or drinking.

On October 5, 2015 PSW #107 was observed providing eating assistance to resident's #005, #046 and #047 simultaneously. This PSW was interviewed and indicated that there are only two staff to assist residents that require eating assistance and monitor those that require 1:1 assistance due to wandering.

During an interview with the dietitian she confirmed that no staff member should simultaneously assist more than two residents who need assistance. [s. 73. (2) (a)]

4. The licensee has failed to ensure that residents who require assistance with eating or drinking is served a meal when someone is available to provide the assistance.

According to the current care plan for resident #044, this resident is a moderate nutritional risk. The most recent nutritional assessment completed by the home's Registered Dietitian on September 21, 2015 indicates resident #044 is at "risk of inadequate calorie, protein and fluid intake.

PSW #121 was interviewed and indicated resident #044 requires total assistance at meals. During dining observation on October 1 and 2, 2015, resident #044 required total assistance at lunch meal.

Dining observations were made in the main dining room on September 28, October 1 and 2, 2015.
At approximately 1224 hrs, resident #044 was observed to be provided with assistance with the lunch meal until 1228 hrs when PSW had to leave to attend resident #045 at the other end of the table. This PSW continued to assist resident #045 until 1236 hrs at which time she left the dining room.

Resident #044 was provided with dessert of ice cream at 1240 hrs, no assistance was provided for the resident to eat. At 1245 hrs staff #120 approached resident #044 and fed him/her the ice cream, which had begun to melt.

Between 1224 hrs and 1245 hrs resident #044 was not provided with assistance to eat his/her entrée or dessert.

Resident #032 current nutritional care plan indicates resident requires "intermittent encouragement and physical assistance to ensure adequate nutritional intake and more assistance may be required depending on his/her physical well-being." The current nutritional care plan also directs staff to monitor resident closely as he/she has a history of choking.

PSW #121 was interviewed and stated the type of assistance resident #032 requires depends on the day, but at minimum does require cueing.

During dining observation completed on September 28, 2015, this inspector observed resident #032 to feed themself some of the entrée, with cueing from staff. Resident #032 was then provided with dessert (an ice cream cup) and no assistance was provided. This Inspector and Inspector #103 observed resident put the ice cream into the glass of juice and struggled to eat independently. No cueing or assistance was provided to the

resident.

During dining observation on October 1, 2015 inspector observed resident #032 receive soup at 1208 hrs, when he/she appeared to be sleeping. At 1219 hrs resident was woken up and cueing provided to eat the soup which was not re-heated. Later in the lunch meal resident #032 attempted to eat the pudding without assistance from staff however the resident was unable to get the spoon into his/her mouth throughout this observation. Resident was observed to quickly touch spoon to their mouth and then back to bowl, and repeat this motion. No staff member was present at resident #032's table to provide assistance or monitoring. At the end of the meal service, PSW #122 did return to provide resident #032 with total assistance to finish the dessert.

The home failed to ensure that residents #044 and #032, who require assistance with eating or drinking, were only served a meal when someone is available to provide the assistance. [s. 73. (2) (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 staff are seated while providing eating assistance to residents, staff don't simultaneously assist more than two residents who need total assistance with eating or drinking and resident's who require assistance with eating or drinking are not served a meal until staff are available to provide the required assistance, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 87(2)(d) in that incidents of lingering offensive odours are not addressed.

Throughout the inspection, lingering offensive odours were identified in resident #023's bathroom. Housekeeping staff were observed cleaning the bathroom on a daily basis. Immediately following the cleaning of the bathroom, the odours would resolve for a short period of time, but would become evident again within one to two hours. This inspector did not find inappropriate disposal of garbage or spills on the floors as a reason for the odours.

Housekeeper #141 was interviewed, stated the bathrooms are cleaned daily and stated the housekeepers do have products they use when odours are identified and that they were being utilized in resident #023's bathroom. The housekeeper stated the Laundry aide that returns the clothing to the resident closets monitors for odours throughout the home.

The Environmental Manager was interviewed and showed this inspector the odour removal products currently in use in the home. She stated that the floor in this bathroom may require replacing as many of the odours are a result of longstanding soiling that permeates into the flooring. [s. 87. (2) (d)]

2. During the course of the inspection, lingering offensive odours were noted in the following areas:
- the Willow Wing bathroom located off the dining room,
-resident #012 and 022 shared bathroom,
-resident #06 bathroom,
-resident #012, 014, and 037 shared bathroom,
-resident #036's bedroom on the bedroom floor and east wall.

The housekeeping aides #124 and #113 were interviewed and confirmed that the bathroom floors are cleaned daily and the odour in the resident bathroom off the dining room on the Willow Wing has been an issue for the past two to three years. Both indicated that measures used to resolve the odour have been unsuccessful, including the replacement of the bathroom floor.

Housekeeping aides #124 and #113 confirm the lingering odours in the resident shared bathrooms and that the urine odour appears to have permeated through the areas of floor in disrepair causing the lingering odor.

The Environmental manager was interviewed and confirmed that she has been aware of the odours and that a budget request to replace the flooring has been submitted to corporate office for approval. [s. 87. (2) (d)]

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 lingering offensive odours identified in the Willow wing bathroom off of the dining room, bathrooms for residents #012, #022, #06, #014, #037, #032 and #036's bedroom are addressed, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home for each verbal and written complaint as outlined in the legislated requirements.

Resident #048's family submitted a written letter of complaint to the home on an identified date, that alleged staff to resident abuse.

The Administrator was interviewed and recalled receiving the written letter but was unsure of the exact date she became aware of it. The Administrator stated she had met with resident #048's family on an identified date at which time she reviewed the home's action. The Administrator stated the family member was happy with the outcome.

This inspector asked to review the home's documented record of complaints and noted there was no record of the written complaint received by the home from resident #048's family member. [s. 101. (2)]

2. The licensee has failed to ensure the documented record is reviewed and analyzed for trends at least quarterly.

The home's documented record of written and verbal complaints was reviewed for 2015. The home had recorded one verbal complaint dated March 31, 2015 one verbal complaint dated April 2, 2015 and one written complaint dated September 17, 2015 for the current year to date of this inspection. There was no documented evidence to support the documented record had been reviewed and analyzed for trends at least quarterly.

The Administrator was interviewed and stated she was unaware this was a requirement. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a documented record is kept in the home for all verbal and written complaints and it is maintained in accordance with the legislated requirements and the documented record is reviewed and analyzed for trends at least quarterly, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 r. 129(1)(a)(ii) whereby drugs are not stored in an area or a medication cart that is secure and locked.

On September 30, 31, and October 2, 2015, prescribed resident treatment creams were observed in the PSW care carts unlocked and unattended on the Willow Wing. Resident #022 and #037 who are cognitively impaired were observed wandering in the vicinity of the cart.

On September 28, 30 and October 1, 2015, prescribed resident treatment creams were observed in the PSW care carts on the Maple and Lilac home areas unlocked and unattended.

Examples of prescribed treatment creams include the following:
-Voltaren cream 1.16%
-Ketaderm 2%
-Nizoral 2%
-Uremol 10%
-Nyaderm
-Clotrimaderm 1% and Mometasone 1%

On October 1, 2015, PSW's S#111, S#128, S#107, S#116 and RN S#119 were interviewed and confirmed that the care carts are to be locked at all times.

The DOC also confirmed that the prescribed resident treatment creams are to be locked in the care carts. [s. 129. (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 prescribed resident treatment creams are stored in an area that is locked when not being used, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 131 (4) whereby a member of the registered nursing staff permitted staff members who are not otherwise permitted to administer a drug to a resident to administer a topical without ensuring the staff member was first trained in the application of the topical.

PSW S#111, S#128, S#107 and S#116 were interviewed and confirmed they were permitted to administer topical medication without training or supervision.

RN S#119 was interviewed and confirmed that she has not provided training or supervision to staff who are not otherwise permitted to administer a topical medication.

The Director of Care was interviewed and stated it was her expectation that registered staff provide training and supervision to the personal support workers to administer topical medications. [s. 131. (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 all staff not otherwise permitted to administer a drug to a resident receives training in the administration of topicals, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure the interdisciplinary team that coordinates and implements the Infection control program meets at least quarterly.

In an interview with the DOC, she was asked to provide the inspector with a copy of the meeting notes for the Infection control program (ICP). The DOC stated there are no notes to provide as there have been no ICP meetings held in 2015. [s. 229. (2) (b)]

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

On October 2, 2015 during the lunch meal service, this inspector observed a PSW gathering the soiled shirt savers from the resident tables. This staff member was then observed to approach resident #009 who requires total feeding assistance. The PSW was observed to place the soiled shirt savers on the floor beside her, and sat down next to resident #009 and began feeding the resident. No hand hygiene was observed prior to helping this resident with lunch. [s. 229. (4)]

3. On October 6, 2015 during the breakfast service, this inspector observed two PSW's disposing of soiled shirt savers in the bin (located just outside of the dining room next to a hand sanitizing station) and then returned to the dining room and were observed to sit with residents to assist them with breakfast. Neither of the PSW's hand sanitized prior to providing this assistance to the residents.

In addition, a PSW was observed holding a large collection of soiled shirt savers next to her uniform prior to disposing of them and another PSW was observed using the soiled shirt saver to clean a resident's face.

A PSW was then observed removing resident #010 from the dining room and assisted the resident into the bathroom located outside of the main dining room. The PSW was observed to return the resident to the dining room and hand hygiene was not observed upon leaving the bathroom. This PSW then proceeded to assist another resident to finish breakfast. When the PSW got up from assisting this resident, she proceeded to collect soiled shirt savers, disposed of them and then began transporting resident out of the dining and back to their rooms, all without hand sanitizing.

PSW #132 was interviewed in regards to the use of resident nail care equipment in the home. The PSW stated the home utilizes shared nail care equipment and confirmed residents do not have dedicated equipment for nail care. This PSW was asked to explain the process for cleaning and disinfection of this equipment. The PSW stated that she uses Mikro-Quat to clean the clippers and if the nail clippers are visibly dirty with nails,

she removes the nails and then soaks the clippers in the Mikro-Quat for ten to fifteen minutes.

PSW #121 was also interviewed in regards to the disinfection practices used to clean shared resident nail care equipment. This PSW stated she uses alcohol to clean the clippers between use.

PSW #128 states she sprays the clippers with Mikro-Quat between residents.

All three of the PSW's stated they work on the bath team on a regular basis.

The home's current policy for nail care, IC-B25 indicates for foot care equipment to use activated glutaraldehyde 2% solution and soak for ten minutes and rinse. The policy indicates nail clippers are to be soaked in alcohol for ten minutes.

The Environmental Manager (EM) was interviewed in regards to the disinfection of shared resident care equipment such as nail equipment. The EM stated she believed the Mikro-Quat would be an effective means of disinfecting the clippers as this is the product used for disinfection of the tubs. The EM stated there are no other disinfection products currently being used in the home and was unaware a high level disinfectant would be required for the resident, shared nail equipment.

Mikro-Quat is a hospital grade disinfectant. The label indicates it is not to be used as a terminal sterilant or for high level disinfectant on any surface or instrument.

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in All Health Care Settings, 3rd Edition, Provincial Infectious Diseases Advisory Committee (PIDAC) is the prevailing best practice document in Ontario for the reprocessing of shared and/or re-usable resident care equipment. Critical equipment/devices includes foot care instruments and any instruments that enter sterile tissues, including the vascular system. These items present a high risk of infection if the equipment/device is contaminated with any microorganism, including bacterial spores. Reprocessing critical equipment/devices involves meticulous cleaning followed by sterilization. Semi critical equipment/devices includes shared use nail clippers. Reprocessing semi critical equipment/devices involves meticulous cleaning followed by, at a minimum, high-level disinfection.

Measures are not in place in the home for the cleaning, disinfection or sterilization of

reusable and/or shared resident equipment which poses a potential cross infection risk to residents. [s. 229. (4)]

4. The licensee has failed to ensure every resident admitted to the home has been screened for tuberculosis within fourteen days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Resident #056 health care record was reviewed. The resident was admitted on an identified date and the resident's record indicated the resident's last chest x-ray was completed in 2011. There was no documentation to support this resident received a chest x-ray within the 90 days prior to admission or fourteen days after admission.

Resident #57 health care record was reviewed. The resident was admitted on an identified date and the resident's record indicated the resident's last chest x-ray was completed in 2013. There was no documentation to support this resident received a chest x-ray within 90 days prior to admission or fourteen days after admission.

The DOC was interviewed and informed this inspector she is the lead for the Infection Control Program. The DOC was asked how the home is currently screening for tuberculosis (TB) and she stated the screening was done by means of a two-step mantoux test. According to the DOC, the home does not have a current policy for the screening of TB. The DOC stated she was unaware of any new recommendations by the Public Health Unit in regards to TB screening.

RN #105 was interviewed and stated the home has been screening for tuberculosis by means of a chest x-ray for quite some time. The RN indicated the RN's are responsible for the most part in ensuring the resident immunizations are up to date. The RN was asked to describe the screening process and indicated residents are to have a chest x-ray completed prior to being admitted to the home. This inspector asked what the home would do if the resident had not had a chest x-ray prior to admission and the RN stated she believed the home would have to try and get one completed. The RN was questioned about the timelines for the chest x-ray and the RN stated she was not aware of any. [s. 229. (10) 1.]

5. The licensee has failed to ensure that resident's are offered immunizations against pneumoccocus, tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Resident #055 was admitted on an identified date. The resident's health care record was reviewed and there was no indication of when the resident was last given diptheria and tetanus immunizations and there was no evidence this resident was ever offered these immunizations.

Resident #057 was admitted on an identified date. The health care record was reviewed and a consent had been signed by the family on an identified date for diptheria and tetanus. The record did not contain information related to the last date the resident received these immunizations and there was no documented evidence to support this resident was ever offered or received the immunization. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the interdisciplinary team that coordinates and implements the Infection Control program meets at least quarterly, to ensure all staff participate in the hand hygiene program, to ensure the home disinfects shared resident care equipment using a high level disinfectant, ensure each resident admitted to the home has been screened for tuberculosis within 90 days prior to admission or within 14 days after admission to the home and to ensure all residents are offered immunizations against pneumoccocus, tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #14: 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 the nutrition care and hydration programs include the development and implementation of policies and procedures relating to nutrition care and dietary services and hydration, in consultation with a dietitian who is a member of the staff.

As per O.Reg 79/10 s. 8(1) where this Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, 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 all applicable requirements under the Act; and b.) is complied with.
O. Reg 79/10, s. 68 (2)(a) states, Every licensee of a long-term care home shall ensure that the programs include, the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

Policy titled Weight Change was provided to inspector. This policy states that nursing will re-weigh residents with questionable weights to ensure accurate assessment.

The weights were reviewed for resident #014 for June, July, August, September and October 2015.

Resident #014's weight for August reflects a significant weight gain of 10.8 kg (19.0%) over a 1 month period. Resident's weight for September reflects a weight loss of 8.6 kg (12.7%) over a 1 month period and resident's weight for October reflects a weight gain of 4.2 kg (7.1%) over a 1 month period. There are no documented re-weighs for the identified weights.

Resident #014 was assessed by the home's Registered Dietitian on September 8, 2015. The assessment indicates that resident's weight on August 24, 2015 may be an error however the assessment did not indicate if a re-weigh was completed.

During an interview, RPN S#100 indicated if a resident's weight looked to be "off" then a re-weigh would be completed. Upon review of resident #014's weights with inspector, S#100 indicated that the weights did appear to be off however she could not confirm if a re-weigh was completed.

During an interview with the Environmental Manager,she confirmed that resident #014 did not have a re-weigh completed for weights entered August, September and October 2015.

The weights were reviewed for resident #009 for June, July, August, September and October 2015.

Resident #009's weight for September 3, 2015 reflects a significant weight loss of 8.3 kg (15.5%) over a 1 month period and weight October 1, 2015 reflects a significant weight gain of 8.2 kg (18.1%) over a 1 month period.

Resident #009's electronic health record including weights and progress notes were reviewed from September 1, 2015 to current date and there is no indication that a re-weigh was completed.

During an interview with staff #S118 she confirmed that resident #009 did not have a re-weigh completed for weight entered on September 3, 2015. [s. 8. (1) (a),s. 8. (1) (b)]

WN #15: 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. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The Administrator was interviewed in regards to the newly completed, secure outdoor area that can be accessed from the Willow Wing. According to the Administrator, the area is now open and can be accessed by residents, family and staff.

This inspector requested the policy for the door leading to this secured area and was advised the home does not currently have a written policy for this door. [s. 9. (2)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure written complaints received by the home that concern the care of a resident or the operation of the long-term care home were immediately forwarded to the Director.

A written complaint was received on a specified date from resident #048's family and alleged abuse of the resident by staff. The home has not forwarded this written complaint to the Director to date of this inspection.

On another identified date, a written complaint was sent to the home from resident #038's family in regards to the care of resident. To date of this inspection, this written letter of complaint has not been forwarded to the Director.

The Administrator was interviewed in regards to these written letters of concerns and stated she was unaware they had to be forwarded to the Director. [s. 22. (1)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond to concerns or recommendations, within 10 days in writing, that are raised by the Resident Council.

The Resident council minutes were reviewed for 2015. On June 11, 2015, residents raised concerns in regards to the dining room noise and the wait times for food since the second floor residents began eating in the main dining room. No written response was received in response to these concerns.

On July 16, 2015, the residents raised further concerns in regards to the main floor dining room noise level, crowded space and meals taking longer to serve. A written response dated July 31, 2015 and August 13, 2015 was provided to the resident council but was not within 10 days.

On August 20, 2015, the Resident council president met with Susan Turnbull to further discuss dining room issues and requested the dining room doors be opened earlier to avoid congestion in the hallways prior to meal service. No written response was found. [s. 57. (2)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to respond to concerns or recommendations, within 10 days in writing, that are raised by the Family Council.

The Family Council minutes were reviewed for 2015. On May 11, 2015 concerns were raised in regards to the relocation of the palliative care room and the removal of the furniture from the previous palliative care room

On July 13, 2015, a family member raised concerns in regards to the communication between the physician and the pharmacy whereby a medication change resulted in a resident not receiving a newly prescribed medication for three weeks and concerns were raised about the process of reassigning a resident to another room.

No written responses were found for any of the concerns raised. [s. 60. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure there is a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

Of the 40 resident census records reviewed, inspectors identified multiple residents who have not had an annual height completed.

RPN #100 indicated to inspector during an interview that heights are completed on admission and she is unaware of a process to complete heights annually. During an interview on October 7, 2015, the Environmental Manager confirmed that the home does not have a process to ensure heights are completed on an annual basis. [s. 68. (2) (e) (ii)]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' and the Family Councils in developing and carrying out the satisfaction survey, and in acting on its results.

The Presidents of the Resident and Family Councils were interviewed and could not recall if the licensee had sought their advice in the development and carrying out of the 2014 satisfaction survey. Upon review of the resident council meeting minutes, this inspector was unable to find documentation to reflect that the satisfaction survey was completed for 2014.

Resident Services Manager who is the assistant for the resident council, informed this inspector that the 2014 satisfaction was provided to families of the home however the resident and family councils were not involved in the development or carrying out of the survey. [s. 85. (3)]

2. The licensee has failed to ensure the results of the satisfaction survey are documented and made available to the Resident and Family Councils.

The Presidents of the Resident and Family Councils were interviewed and could not recall if the results of the satisfaction survey was discussed with the Councils for the 2014 satisfaction survey.

Upon review of the resident council meeting minutes, this inspector was unable to find documentation to reflect that the satisfaction survey was completed for 2014. The Resident Services Manager who assists the resident and family councils, informed this inspector that the 2014 satisfaction was provided to families of the home however the survey results were not discussed with the resident or family councils.

The Administrator was able to show Inspector #103 that a small number of 2014 surveys were returned to the home, but there was no evidence that the results were ever summarized or made available to the resident or family councils.

The Administrator further stated to Inspector #103 that no satisfaction survey has been conducted to date of this inspection for 2015. [s. 85. (4) (a)]

Issued on this 10th day of November, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103), AMBER MOASE (541), HEATH HEFFERNAN (622), SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2015_396103_0053
Log No. / Registre no:	O-002649-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 10, 2015
Licensee / Titulaire de permis :	COUNTY OF PRINCE EDWARD 603 Highway 49, R R 2, PICTON, ON, K0K-2T0
LTC Home / Foyer de SLD :	H.J. MCFARLAND MEMORIAL HOME R.R. #2, 603 HIGHWAY 49, HALLOWELL TOWNSHIP, PICTON, ON, K0K-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Ferguson

To COUNTY OF PRINCE EDWARD, 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
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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 :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee is hereby ordered to address the non compliances identified under LTCHA, 2007, s. 6 (1) as follows:

Ensure resident #042's care plan is updated to include the interventions required to safely apply the smoking apron.

Update resident #020's care plan to accurately reflect the resident's mobility status, ADL requirements and restraints that are currently ordered.

Update resident #044's care plan to accurately reflect the residents toileting and continence care requirements.

Ensure all residents that have been assessed as high risk of falls have the risk included in the plan of care as well as specific safety precautions and fall prevention measures in place to reduce the risk.

Implement a system to ensure front line staff have convenient access to the most current care requirements of every resident in the home.

Grounds / Motifs :

1. The licensee has 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.

On September 29, 2015 on or about 1400hr, Inspectors #541 and #103 observed resident #042 in a wheelchair in the main hallway outside of the family dining room. The resident was observed to have a device applied in such a way that it prevented the resident from being able to remove the device. Resident #042 was interviewed and confirmed he/she was unable to remove the device.

Inspector #103 spoke with RN #105 who stated the resident had just began using this device and that she had applied it this morning. The RN was asked to come and observe the resident and she noted the device was applied in such a way the resident would not be able to remove it on their own. RN #105 stated she had not applied the device in that manner and suggested one of the co-residents may have altered the device. RN #105 stated she would ensure staff were educated on how to properly apply the device.

On October 1, 2015, Inspectors #103 and #541 both observed resident #042 being pushed in the main hallway of the nursing home by a PSW. The resident was observed to be wearing the same device and it was applied in such a manner that the resident could not remove it on their own. The resident was transported to the main doorway of the home where he/she was left.

Inspector #103 asked the DOC to come and observe Resident #042. The DOC noted the application of the device and stated she had just seen a PSW take this resident out of the tub room and bring them downstairs. The DOC was informed of the previous incident and the discussion that had taken place with RN #105. The DOC acknowledged the device was applied in a manner which would be considered a restraint. She concluded the staff member must have inappropriately applied it after the resident bath.

RPN #106 was interviewed and stated she had been working days all week and confirmed she had been giving shift report to the oncoming staff for the evening shift. The RPN was asked what information was being forwarded to staff during this report in regards to resident #042's newly acquired device. The RPN stated there was no information relayed to staff in regards to this and stated the application of this device was common sense.

Resident #042's care plan was reviewed and indicated a specified diagnosis.

The care plan failed to indicate the resident had this device and did not provide any direction to staff in regards to when or how to apply, remove it. [s. 6. (1) (c)]

2. Resident #020 had a specified diagnosis. The resident progress notes were reviewed from July 1, 2015 to date of this inspection. On a specified date, resident #020 fell and sustained an injury. According to staff, the resident was independent with transfers at the time of this fall.

Eight days later, the progress notes indicated the resident was attempting to unsafely self transfer. The following day, the staff documented the resident was assisted by a co-resident to transfer, but a fall was avoided. On a specified date, the Physiotherapist (PT) assessed the resident as high risk for falls and stated staff would be advised to use one staff to assist the resident to and from the toilet and bed, and that 2 staff could assist the resident to and from the dining room.

Four days after the PT assessment was completed, the progress notes indicated the resident was taken to a lounge and left there unattended to listen to music. The resident fell again and sustained a second injury. The post fall notes indicated the resident was wearing inappropriate foot wear.

RN #119 was interviewed and had been working at the time of this second fall. The RN indicated the PSW staff had left resident #020 to answer call bells and found the resident on the floor in the lounge when they returned. The RN was asked to comment on her documentation that indicated the resident was wearing inappropriate foot wear. The RN stated the resident had slippers on with slippery bottoms and stated she felt it would be unusual for staff to walk the resident in this type of footwear but thought perhaps the resident did not have appropriate footwear to be used. The RN stated staff believed the resident fell because he/she attempted to stand on their own and slipped.

The resident care plan in place at the time of this second fall, failed to identify the resident as a high risk for falls. It did not include interventions to address the previously documented instances whereby the resident had attempted to self transfer following the fall that resulted in the first injury. The care plan also failed to identify common safety risks such as ambulating only when appropriate foot wear was in place. [s. 6. (1) (c)]

3. Resident #020's most recent Minimum Data Set (MDS) assessment indicated resident requires total assistance with one to two person assist for dressing, bathing, transferring, toileting and personal hygiene. ADL RAP completed

August 1, 2015 indicated resident requires extensive assistance with ADL tasks caused by progression of cognitive impairment and recent fall resulting in injury.

During an interview, PSWs #109 and #130 stated that resident #020 required total assistance with transfers. PSWs #109 and #130 stated the resident cannot weight bear, needs staff assistance to dress and uses a mechanical lift for transfers. PSW #130 stated the resident can eat independently with staff encouragement.

Physiotherapist #129 stated during an interview with inspector that Resident #020 is not able to weight bear and requires total assistance with bathing, dressing, toileting and transfers.

Resident #020's current plan of care effective August 11, 2015 indicated the following:

Dressing: Provide constant supervision and assistance, report any decrease in ability to dress self in a clean and appropriate manner.
Transfers: Resident can weight bear and transfers with 2 staff at all times.
Toileting: Goal for resident is to maintain ability to toilet self safely. Staff to provide some guidance and direction in locating washrooms related to cognitive impairment and periods of confusion.
Bathing: One person physical assist while bathing

The plan of care for resident #020 does not set out clear direction to staff in that it does not reflect the residents current care needs. [s. 6. (1) (c)]

4. PSWs #120, #111 and #109 were interviewed to determine how they know a resident's level of mobility, any restraints that are to be applied or any other pertinent care needs. All three of the PSW's stated the information was previously recorded in the resident room inside their closets and highlighted those details. All stated, they found this information helpful and it was convenient. All indicated these were no longer either available or accurate. Resident #020's closet was checked and did have an outdated logo posted that indicated the resident could transfer with minimal assistance. PSW #109 stated she had worked in the home for several years, but stated she does not always work in the same area of the home and it can be difficult to keep up with changes. Another PSW stated if there was a seat belt on the resident chair, she would latch it and try to find out later if the resident had an order for the restraint.

PSW staff indicated it is especially difficult for newly hired staff. PSW #128 is a newly hired worker and stated it is difficult to know the resident's care needs without asking co-workers. [s. 6. (1) (c)]

5. Resident #044 was observed sitting in the common area at 0900 hours and observations were made until 1325hr when the resident was returned to bed. The resident was not toileted during this observation time.

Resident #044's care plan in effect at the time of this inspection indicated: resident is toileted A.C., P.C., A.M. and H.S; wears a medium brief.
Under Urinary Incontinence; INCONTINENT PROGRAM: Toilet ac, pc meals and qhs.

PSW staff were interviewed and indicated the resident is no longer toileted. The care plan fails to provide clear direction to staff.(622) [s. 6. (1) (c)]

The decision to issue a Compliance order was based on the following facts:
The home's compliance history was reviewed and the home has had previously issued non compliance issued under LTCHA, 2007, s. 6 (1) as follows:
October 2014- WN, VPC for failure to provide clear directions to staff in the area of continence care and bowel management.

The home has also had related non compliances issued under plan of care as follows:
LTCHA, 2007 s. 6 (2)- WN, CO issued June 2015
LTCHA, 2007, s. (7)- WN, VPC issued October 2014 and
LTCHA, 2007, s. 6 (5)- WN issued April 2013.

The scope and severity of the non compliances were also assessed and determined that a compliance order is warranted given the actual harm that came to resident #020 and the potential harm for resident #042.

(103)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 08, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee is hereby ordered to ensure at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations (O. Reg 79/10 s. 45 (1) 2.) for the home's licensed bed capacity (84 beds) as follows:

i. in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used, and

ii. in the case of an emergency where the back-up plan fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,

-the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and

-a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

In accordance with O. Regs 79/1, s. 45 (2), "emergency" is defined as an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, s. 8 (3) whereby at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

H.J. McFarland is an 84 bed home. In accordance with O. Reg. 79/10 s. 45 (1) 2., a home with a licensed bed capacity of more than 64 beds and fewer than 129 beds have exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as follows:

i. in the case of a planned or extended leave of absence of an employee of the

licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used, and

ii. in the case of an emergency where the back-up plan fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,

-the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and

-a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

In accordance with O. Reg. 79/10, s. 45 (2), "emergency" is defined as an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

This inspector reviewed the registered nursing schedule for the months of June, July, August and September 2015. The following shifts were identified as not having a registered nurse on duty and present in the home that is a member of the regular nursing staff:

July 17, 2015, night shift; The home utilized an agency RPN to replace the shift. There was no RN in the building during the night shift.

July 24, 25 and 26, 2015, night shifts; the home utilized an agency RN. The absence of the regularly scheduled RN for these shifts did not meet the allowable exceptions.

September 25, 2015, night shift from 0200-0700 hr; the home utilized an agency RPN for this shift; there was no RN in the building during this time. The absence of the regularly scheduled RN did not meet the definition of emergency.

The DOC was interviewed and stated she was unaware of the regulations or allowable exceptions to ensure an RN was on duty and present in the home at all times.

The decision to issue a Compliance order is based on the following facts:
The scope and severity of this non-compliance was reviewed. All of the identified shifts were night shifts and there is only one registered staff on site during this shift. The absence of a Registered Nurse, who is familiar with the residents that reside in the long term care home, potentially poses a risk to resident safety and affects every resident living in the home.

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 08, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 110 through the following actions:

-provide education to all registered nursing staff that includes the following:
-a review of the legislated requirements related to restraining by a physical device, specifically:
O. Reg. 79/10, s. 110 (1) 1. Staff apply the physical device in accordance with any manufacturer's instructions,
O. Reg. 79/10, s. 110 (2) 1. Staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, and
O. Reg. 79/10, s. 110 (2) 3. The resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of the staff as authorized by a member of the registered nursing staff for that purpose.

The education should include:
- the proper application of lap/seat belt restraints and the risks associated with poorly fitted belts,
-the importance of resident hourly checks when restraints are in use to ensure proper application and resident safety, and
- the required documentation related to the resident restraint.

The home will outline how staff compliance with the application and monitoring of physical devices that are restraints will be assessed and what actions the home will take when staff are found to be non compliant.

This plan shall be submitted in writing by November 30, 2015 to Inspector, Darlene Murphy by fax at 613-569-9670.

Grounds / Motifs :

1. The licensee has failed to ensure staff apply the physical device in accordance with any manufacturer's instructions.

Resident #038 sustained a fall on an identified date and sustained an injury. On October 7, 2015, resident #038 was observed to be seated in a wheelchair in the area outside of the second floor elevator. The resident was observed to have a front closing lap belt in place and it was observed to be loose such that it could be pulled away from the resident's abdomen four to five inches. The inspector

asked RPN #133 to assess the current placement of the lap belt. RPN #133 stated the lap belt was too loose and with some difficulty, adjusted the belt to a proper fit.

Resident #025 was assessed as high risk for falls and according to staff, the resident had sustained many falls. The resident's progress notes were reviewed and indicated the resident sustained a fall on an identified date. The notes stated the resident was found on the floor still buckled into the wheelchair and further indicated the resident lap belt had been applied too loosely. Registered staff were interviewed and were able to confirm the details of the documented progress note. [s. 110. (1) 1.]

2. The licensee has failed to ensure staff only apply the physical device that has been ordered or approved by a physician or a registered nurse in the extended class.

Resident #025's health care record was reviewed and a physician order and a consent for a rear latching lap belt was found dated April 30, 2015. The resident progress notes were reviewed from July 15, 2015 to date of this inspection. On an identified date, staff documented the resident fell and the resident had undone the seat belt. Staff documented to monitor frequently as resident was unbuckling the belt. The following day, the resident fell again and sustained an injury. Staff documented the resident unbuckled the lap belt and was walking unassisted with poor balance. The staff further documented to consider an order for a table top or lap belt to buckle at the back. RN #105 was interviewed in regards to this fall and indicated resident #025 was currently in a rear latching lap belt and could not undo it. The staff member was unable to explain why a rear latching lap belt had not been in place at the time of the two falls despite the physician's order since April 30, 2015.

Resident #020 was observed in a tilt wheelchair with a front latching seat belt and a tray in place. The resident's health care record was reviewed and the physician had ordered a lap belt (buckle in the back), table top and tilt chair on a specified date. On the same date, the SDM had signed a consent for the same restraints.

Staff were interviewed and stated resident #020 has never had a rear latching lap belt and were unaware of the physicians order or the SDM's consent for the same.

Resident #052 fell and sustained an injury on a specified date. The resident health care record was reviewed in regards to restraints ordered for fall prevention. The resident was observed to be seated in a wheelchair with a rear latching seat belt. When staff were interviewed, they stated the rear latching belt was in place as the resident had previously fallen with injuries and was able to undo a front latching lap belt. Staff indicated the rear latching belt was a means of ensuring the resident did not unsafely transfer on his/her own and that the resident was unable to remove the rear latching belt, therefore making it a restraint for resident #052. The physician orders for this resident was reviewed from January 2015 to date of this inspection. A physician order was not found for the rear latching lap belt restraint or any form of restraint. The resident's SDM had signed a consent for a lap belt, tabletop and tilt chair on August 17, 2015. [s. 110. (2) 1.]

3. As discussed in WN #1, staff applied resident #042's device in a manner which restrained the resident. There were no physician's orders in place in regards to a physical restraint for resident #042 and it put the resident at risk of harm due to his/her inability to remove the device. [s. 110. (2) 1.]

4. The licensee has failed to ensure the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

On October 7, 2015 at 0940hr, this inspector had observed a loosely fitted seat belt for resident #038 and asked RPN #133 to reasesss the restraint. The restraint monitoring book was reviewed following the RPN's adjustment of the lap belt and this inspector found that all second floor restraints that were included in the restraint monitoring book had been signed off by the RPN at 0930hr for the day shift.

RPN #133 was interviewed in regards to the monitoring process in place for resident restraints. According to this staff member, each resident that has a restraint in place will have a restraint monitoring sheet that indicates the type of restraint in place. She further stated, registered staff must sign off on these sheets every shift. The RPN indicated it doesn't matter what time the sheets are signed off, but they must be signed every shift. The RPN indicated signing off indicates you are aware of the restraint ordered for the specific resident and that

it is properly in place.

On October 6, 2015, RPN #131 was interviewed in regards to the resident restraints currently in place for resident #020 and stated this resident uses a front closing lap belt and a tray. The RPN stated the PSWs and the registered staff ensure the restraints are applied as ordered. Additionally, the RPN stated the registered staff sign off on a restraint monitoring sheet every shift to indicate the restraints are properly applied. The RPN checked for the monitoring sheet for resident #020, and stated the resident did not have one. According to the RPN, the night staff ensure new restraint forms are prepared for the beginning of each month and that she would need to start one for resident #020.

Resident #052 was also found to have no restraint monitoring sheet as of October 6, 2015.

Restraint monitoring sheets for resident #020 and #052 had not been completed from October 1 to October 6, 2015 or noted to be absent until such time the inspector interviewed staff.

The DOC was interviewed and indicated the restraint monitoring sheets are to accurately reflect the ordered restraints for the resident. She also indicated the registered staff are to sign off every shift and this signature indicates they have monitored the resident while restrained and the restraint is properly applied. [s. 110. (2) 3.]

The decision to issue a Compliance order was based on the following facts:
Resident #038 and #025 were improperly restrained such that their lap belts were too loose which posed a risk of harm to both residents. A poorly fitted lap belt poses a strangulation risk to residents.
Resident #052 and #042 had the potential for harm as neither had a doctor's order for their restraints.
Resident #020 was not restrained in accordance with the doctor's orders and therefore had a risk of harm. Staff were unaware of the appropriate order in place.

Overall, the scope was identified as a pattern due to the number of residents with restraint related issues identified during this RQI.

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 18, 2016

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 : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is hereby ordered to comply with LTCHA, 2007, s. 6 (7) as follows:

Ensure resident # 026 and resident #049 receive the care related to the toileting as specified in their plans of care.

Develop a process whereby staff are responsible for ensuring all residents with fall prevention measures in place such as chair and bed alarms are in good working order at the beginning of each shift.

Ensure resident #025 is restrained in accordance with the physician's orders.

Ensure resident #038 is receiving the assistance to mobilize with the walker in accordance with the plan of care.

Grounds / Motifs :

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

The following findings relate to Log #O-002567-15:

On October 6, 2015, this inspector made observations of resident's #026 and #049 in regards to their toileting routines.

Resident #026 was observed from 0955hr until 1355hr and was not toileted during that time.

The resident's care plan in place at the time of this inspection was reviewed and

indicated under Toileting:
-staff supervision and physical assistance of two staff for safety ie. adjust clothing, wash hands, pericare and application of product; resident should not be left alone to toilet for safety reasons.
Under ADL program: resident is participating in a Prompted voiding program in an attempt to improve level of incontinence.
Resident #026's kardex was also reviewed and indicated:
Approach resident at scheduled prompted voiding time ie: 0700, 0900, 1100, 1300. (15 minutes before or after assignment time are acceptable).

PSW staff were interviewed and stated this resident was not toileted in accordance with the plan of care.

Resident #049 was observed from 0955hr to 1355hr and the resident was not toileted during this time.

The resident's current care plan dated 09/02/2015, indicated under Incontinence:
Toilet routinely when gets up and before and after meals.
The resident Kardex for toileting was reviewed and indicated:
Approach - resident at scheduled prompted voiding time ie: 0700, 0900, 1100, 1300. (15 minutes before or after assignment time are acceptable).
Encourage resident to ask for toileting assistance, as needed.
Provide resident assistance with toileting
TOILETING - One person constant supervision and phys assist for safety ie. adjust clothing / wash hands / pericare.

PSW staff were interviewed and stated the resident was not toileted according to the plan of care. [s. 6. (7)]

7. On August 19, 2015, resident #052 was observed by this inspector to be self transferring into a chair by the window. The resident was observed to be very unsteady and was seen partially climbing over a wheelchair which was positioned directly in front of this chair. RPN #133 was asked to assist with the resident and the physiotherapist aide #134 went to find the PSW who was assigned to the resident. According to the PSW, she had just left resident #052 in his/her bed a short time ago. RPN #133 stated the battery for the bed alarm must be dead as it had not alarmed. Upon examination of the bed alarm, RPN #133 found the battery had been put in backwards. The RPN properly inserted

the battery and the bed alarm was then functioning.

RPN #133 was asked to explain the process for ensuring bed and chair alarms are in good working order. She stated she did not think there was an actual process and that if a PSW happened to find an alarm not working, it would be reported to her and she would locate a new battery. The RPN stated the bed alarm was an important fall prevention measure for this resident because resident #052 had recently sustained an injury and was known to unsafely transfer independently.

RN #119 was interviewed and stated the home does not currently have a process for checking to see if bed/chair alarms are working, but stated she believed RN #115 was looking into getting something in place. [s. 6. (7)]

8. During a review of resident #025's progress notes, this inspector noted the resident had sustained a fall on an identified date which resulted in an injury. RN #115 had documented the resident's bed alarm was not in working order.

The RN was interviewed and stated she couldn't recall if the battery needed changing, but confirmed the bed alarm was not functioning at the time of the fall and did not sound at the time of the fall. This RN indicated this resident has had many serious falls and confirmed the bed alarm was an important fall prevention measure to alert staff when the resident was attempting to self transfer. The RN was asked who is responsible for checking the functionality of the chair/bed alarms and stated the home does not have a process to her knowledge in regards to checking the chair/bed alarms at this time.

The DOC was interviewed and stated it would be her expectation, that staff would ensure all fall prevention measures were in good working order at the beginning of every shift.

Approximately one month later, staff documented the resident fell because the resident had undone the seat belt. Staff documented to monitor frequently as resident was unbuckling the belt. The following day, the resident fell again and sustained another injury. Staff documented the resident unbuckled the lap belt and was walking unassisted with poor balance. The staff further documented to consider an order for a table top or lap belt to buckle at the back. RN #105 was interviewed in regards to these falls and indicated resident #025 had a front latching seat belt at the time of those falls. The RN stated the resident is

currently in a rear latching lap belt and could not undo it. The staff member was unable to explain why a rear latching lap belt had not been in place at the time of the two falls as indicated in the care plan.

The resident's care plan in place at the time of these falls was reviewed and indicated the following:

Use of an external device for prevention of injury to self characterized by high risk for injury/falls. Under Interventions, the care plan stated: use safety devices, rear closure seat belt when in wheelchair.
Staff failed to ensure the care set out in the plan of care was provided as specified in the plan. [s. 6. (7)]

9. In regards to Log #O-002295-15:

Resident #038 fell and sustained an injury on an identified date. The Physiotherapist (PT) was interviewed in regards to the therapy this resident was receiving post injury. The PT stated he sees the resident twice weekly for balance and strength training and the PT aide sees the resident four times each week. The PT further stated the resident has regained much of their mobility, however the resident's cognitive status makes it such that his/her decisions are not always good. The PT stated the resident may forget to take the walker with him/her and would put themself at risk for subsequent falls.

The PT stated he had recently met with the resident's family and they were requesting staff walk the resident with his/her walker to and from meals to maintain as much mobility as possible.

This inspector stated she had not seen nursing staff walking the resident to or from any of the meals observed during the RQI. The PT agreed nursing staff are not doing that on a regular basis, but agreed that it is a part of the resident plan of care and is important to maintain the resident's mobility.

This inspector noted on the dashboard of the electronic charting system, an entry with a specified date date which indicated resident #038 was to be walked to and from meals and all activities. [s. 6. (7)]

The decision to issue a Compliance order was based on the following facts:
The compliance history was reviewed and the home has had previously issued

non compliance issued under LTCHA, 2007, s. 6 (7) as follows:
October 2014- WN, VPC for failure to provide care set out in the plan of care to the resident as specified in the plan.

The home has also had related non compliances issued under plan of care as follows:
LTCHA, 2007 s. 6 (2)- WN, CO issued June 2015
LTCHA, 2007, s. 6 (1)- WN, VPC issued October 2014 and
LTCHA, 2007, s. 6 (5)- WN issued April 2013.

The severity was assessed as follows:
Resident #026 and #049 had an identified potential for harm by staff failing to assist the resident's with toileting.
Resident #052 had an identified potential for injury due to the non functioning bed alarm that was put into place to alert staff to unsafe transfers out of bed.
Resident #025 had identified harm as a result of a fall due to a non functioning bed alarm and the application of a lap belt that was not in accordance with the doctor's orders.
Resident #038 had an identified potential for injury due to the staff failing to provide ambulation in accordance with the prescribed treatment post fracture.

The scope of the incidents was identified as pattern.

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 08, 2015

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 10th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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