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
May 25, 2015	2015_246196_0007	S-000794-15	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive KENORA ON P9N 2W7

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

NORTHWOOD LODGE
51 Highway 105 P.O. Box 420 RED LAKE ON P0V 2M0

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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577), JENNIFER KOSS (616)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 20, 21, 22, 23, 24, 27, 28, 29, 30, May 1, 2015

During the course of the inspection, the inspector(s) spoke with the District Manager/CEO, site Administrator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), RAI Coordinator, Office Clerk, Pinecrest Home DOC and ADOC, Human Resources Manager, Food Services Supervisor, Maintenance Lead and staff member, Activation Lead, Dietary Aides, Residents and Family Members.

During the course of inspection, the inspectors conducted a walk through of all resident care areas, observed the provision of care and services to residents, reviewed the health care records of several residents, reviewed various home policies and procedures.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **38 WN(s)**
- **21 VPC(s)**
- **11 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
O.Reg 79/10 s. 47. (1)	CO #004	2014_211106_0006	616
O.Reg 79/10 s. 50. (2)	CO #002	2014_211106_0006	196

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

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

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

During the inspection, resident #025 was observed and a specific safety intervention was in use. The progress notes indicated this strategy was in use but it was not included in resident #025's plan of care.

On a another day, resident #025 was observed walking in the corridor with staff and the safety intervention was not in use. Later that same day, S #100 reported that the intervention that had been in use for resident safety was removed in order to evaluate the resident. When asked if there were additional strategies to monitor resident #025 without this specific intervention, S #100 stated no and that the Business Office staff would be monitoring the doors. It was then confirmed by S #100 that information pertaining to the use of this specific safety intervention should be included in resident #025's care plan.

The progress notes for resident #025 were reviewed and there was no documentation

pertaining to the removal of the safety intervention and no documentation regarding family notification of its removal. S #111 was questioned regarding this safety intervention and they were unsure if it was still in use and there was no communication shared at shift report about it not being in use. In addition, S #111 reported that staff responds when resident #025 attempts to exit and the door alarm sounds, they would go to the door and redirect resident. They also reported there were no specific techniques they were aware of, but it may take more than one staff person to redirect resident #025. The support of additional or alternate staff required to redirect resident was not included in resident #025's plan.

The written plan of care for resident #025 did not set out clear directions to staff and others who provide direct care to the resident, specifically, there was no reference to the use of this specific safety intervention nor strategies to respond to responsive behaviours in the plan. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

During the inspection, Inspector #577 observed two full bed rails elevated for resident #012. The care plan was reviewed and included the type of transfer and assistance the resident required but did not identify the use of bed rails. The bed rail assessment form indicated the use of toilet and window side assist rail. It was confirmed by S #119, that the use of bed rails should be included in the resident's care plan.

The written plan of care for resident #012 did not set out clear directions to staff and others who provide direct care to the resident, specifically, did not include the intervention of bed rail use. [s. 6. (1) (c)]

3. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

Resident #001 was observed throughout the course of inspection to have a restraint in place while seated in a specialized chair. The monitoring record for the a one week period, was reviewed and did not specify which type of restraint or PASD was in use but

did include the initials of staff that had applied/repositioned/monitored the use of a restraint for resident #001.

The current care plan was reviewed and under the under the focus of "Physical Restraint - PASD", the restraint observed in use was not included in the interventions and instead it listed the use of a seat belt, geri chair, tray table and tilt recline chair. The restraint used by the resident was ordered by the physician in winter 2015.

The written plan of care for resident #001 identified different types of restraints but did not identify the restraint used by the resident, as was observed in place during the course of inspection. As a result, the written plan of care did not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

An interview was conducted with S #110, and the continence status and care needs of resident #004 were reported.

The current care plan under the problem focus of "Continence Care" identified the frequency of incontinence and included interventions for toileting but did not specify a schedule or times that this task is to be performed. Under the problem focus of "Risk of Injury from falls" the interventions included "establish a bowel/bladder routine" but the plan did not identify a routine. Under the focus of "ADL Functional Rehabilitation" the interventions included "Encourage (resident#004) to perform tasks independently, e.g. get out of chair and walk to bathroom" and then it reads "requires two or more persons at this time but if mechanical lift needed will be ceiling lift".

The written plan of care did not set out clear directions to staff and others who provide direct care to the resident, specifically, the plan did not identify when to toilet resident #004, the plan did not include a bowel/bladder routine and it noted that resident #004 could walk to the bathroom when elsewhere in the plan it noted that they couldn't walk. [s. 6. (1) (c)]

5. The licensee has failed to ensure that there is a written plan of care for each resident

that sets out, (c) clear directions to staff and others who provide direct care to the resident.

During the inspection, resident #004 was observed to be seated in a specialized chair with a restraint in place attached at the back of the chair. An interview was conducted with S #110 and it was reported that resident #004 couldn't "really" walk, therefore the restraint was used to keep them safe.

The current care plan was reviewed for information regarding the use of a restraint and a specialized chair. Under the problem focus of "ADL assistance", related to restraint use, the intervention of "Gerri-chair with Traytable" was listed. Under the problem focus of "physical restraints PASD", the plan noted the "use of a trunk restraint and use of a chair that prevents rising" but did not specify the type of trunk restraint to be used or when the restraint was to be used for resident #004.

The "Activation Care plan", included the intervention of "Escort (resident #004) to activity by walking (them) to area right from point A to B as (they) will veer off and not attend" yet as reported by S #110 the resident couldn't walk. In addition, the "Northwood Lodge Hourly Monitoring Record" for resident #004, for a particular month was reviewed for information. The type of restraint in use was not identified on this document, yet staff were recording the application, monitoring and resident response on this form.

The written plan of care for resident #004 did not set out, clear directions to staff and others who provide direct care to the resident. [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.

On a particular day during the inspection, Inspector #577 observed resident #013 lying in their bed after lunch, and a strong smell of urine was noted.

The care plan for resident #013 was reviewed and identified the continence status of the resident and included the intervention of a toileting routine and repositioning of the resident in their chair hourly. The care plan did not indicate a specific toileting schedule.

On another day, during the inspection, resident #013 was observed at 1100hrs, 1200hrs, 1300hrs and 1400hrs, to be seated up in their wheelchair in the same position, and not

re-positioned by staff or toileted. An interview was conducted with S #112 on this same day at 1415hrs, who confirmed that resident #013 had not been toileted today, since getting up in their chair at 0700hrs.

On another day, during the inspection, resident #013 was observed at 0915hrs, 1100hrs, and 1200hrs, to be seated up in their wheelchair in the same position, and not re-positioned by staff or toileted. An interview was conducted with S #108 later that day, and they reported that resident #013 was repositioned, continence care was provided and they were put back to bed at 1330hrs. An interview was then conducted with S #100 and inquired about their expectations concerning repositioning and toileting of residents that are in wheelchairs and cannot reposition themselves. They reported that their expectation is that residents will be repositioned and toileted after breakfast 1000hrs, after lunch and also at 1400hrs.

The care set out in the plan of care for resident #013 was not provided to the resident as specified in the plan, specifically, continence care was not provided and the resident was not repositioned. [s. 6. (7)]

7. 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 health care records for resident #001 were reviewed and the Physician's order sheet included an order for a nutritional supplement to be given. The MAR sheet for resident #001, had an area to record the administration of the nutritional supplement but it was not documented as being provided on two specific days and a "9" was recorded on three other days. According to the legend on the MAR sheet, "9" represents "hold".

Resident #001 was ordered by the physician to receive a nutritional supplement and they did not receive it on five specific days. There was no documentation as to the reason it was not provided.

An interview was conducted with the RD S #116 regarding resident #001's nutritional plan of care. It was reported that at the last resident care conference, it was identified that the resident had been getting a specific diet texture with thickened fluids when they were to receive a different texture diet when alert and a specific diet texture when very lethargic. In addition, S #116 was unclear when the thickened fluids had started and reported that resident #001 shouldn't have been on them.

The nutritional assessment documented, most recently, online by the RD, identified high nutritional risk, continued weight loss, noted that intakes had remained the same and the cause for weight loss was unknown. The assessment also noted "(they) had been getting only a specific diet texture (diet order for that texture when lethargic only), there is a nutritional gap between these two types of texture foods and with increased energy requirements for healing, (they are) likely not getting adequate nutrients or energy" and that they had been on thickened fluids for a period greater than 6 months for an unknown reason.

The care set out in the plan of care, for resident #001, was not provided as specified in the plan, specifically, the incorrect diet texture and thickened fluids was given and not the diet that was originally ordered. [s. 6. (7)]

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

On a particular day, during the inspection, the evening supper meal was observed. Resident #017 was observed to be assisted with with the meal by S #109 and they reported that the resident had thickened juice and tea to drink. An interview was conducted with Dietary Aide S #117 and they reported that the ordered supplement was not provided to resident #017 tonight and a specific type of juice was not provided.

The current care plan, as found at the nursing desk, was reviewed and included the problem of "nutritional care" and the interventions listed a specific type of juice to be offered and the supplement to be provided at meals.

The dietary reference sheet as was posted in the servery, was copied and reviewed for information regarding resident dietary requirements and included the same information as in resident #017's care plan.

The care set out in the plan of care was not provided to resident #017 as specified in the plan, specifically the resident was not offered a specific type of juice and the supplement was not added to the supper meal.
[s. 6. (7)]

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

A copy of the dietary reference sheet posted in the servery was reviewed as the supper meal was observed.

Resident #018 was observed to eat cut up pieces of pork chop, approximately 1cm X 1cm, yet the dietary reference sheet identified a specific texture other than cut, as the food texture that was to be provided. The Dietary Aide S #117 was questioned and confirmed that a cut up pork chop had been provided to this resident.

The current care plan for resident #018 was reviewed and under the problem of "nutritional care" there was an intervention of a specific diet texture.

The care set out in the plan of care, for resident #018 was not provided to the resident as specified in the plan, specifically, the incorrect texture of food was given during the dinner service on a particular day during the inspection. [s. 6. (7)]

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

The health care records for resident #001 were reviewed and the nutritional risk assessment identified this resident to be high risk with a history of 9.5% loss of body weight over a specific period of time. The current care plan, under the focus of nutritional care, included the intervention of "(a nutritional supplement) at PM and HS snack". The "food and nourishment daily record" for an approximate one month period in 2015, did not identify whether a nutritional supplement, for either the PM mid-afternoon nourishment nor the HS evening nourishment, was provided.

An interview was conducted with the RD and it was reported that in December 2014 the nutritional supplement was added to the resident's diet twice daily, at PM and HS snack. When the nutritional assessment was done two months later, it was noted that energy requirements were not being met and upon review by the RD it was determined that the nutritional supplement was not being given to the resident.

On a particular day, during the inspection, the PM snack pass was observed and S #110 was observed to go past resident #001's room and not enter to offer the resident a snack

or beverage. An interview was conducted with S #110 and it was reported that resident #001 was to receive a nutritional supplement at afternoon snack time but it was not given as the resident was too tired and it would just be given at HS if they were sleeping in the afternoon.

Resident #001 did not receive the ordered nutritional supplement on this day during the inspection. In addition, it was confirmed by the RD that this nutritional supplement had not been provided twice daily to resident #001 from December 10, 2014, to February 3, 2015.

An interview was conducted with the RD and it was reported that a different nutritional supplement was increased from TID (three times daily) to QID (four times daily) on a particular day in April 2015. The MAR (medication administration record) was reviewed for the month of April and the increase had not been initiated until eight days after it was ordered.

The care set out in resident #001's plan of care was not provided to the resident as specified in the plan, specifically, the increase of a different nutritional supplement was not initiated until eight days after being ordered by the RD, a different nutritional supplement was not given on a particular day and this same nutritional supplement was not provided by the staff from December 10, 2014 to February 3, 2015. [s. 6. (7)]

11. 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.

Resident #001 had altered skin integrity as documented in the wound consultation note done in January 2015 by the RN EC.

On a particular day during the inspection, resident #001 was observed over a two and a half hour period seated in a specialized chair and the chair was not repositioned.

The current care plan, under the focus of altered skin integrity, included the intervention of "HCA tilts (resident #001) chair to new position hourly".

The care set out in the plan of care was not provided to resident #001, specifically, the resident was not repositioned in their specialized chair hourly. [s. 6. (7)]

12. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary.

Resident #012 was hospitalized for a period of time for illness. Upon record review, the RAI-MDS for the observation period after hospitalization, identified that resident #012's ADL's had further declined, bed mobility had deteriorated and eating had declined and required more assistance. The care plan was reviewed and it did not contain updated information that indicated a further decline in ADL's, bed mobility and eating.

Inspector #577 spoke with S #127, and they reported that there wasn't any updated care plan information changes to reflect the illness and the care plan remained the same.

The written plan of care for resident #012 was not reviewed and revised, to reflect a further decline in ADL's following hospitalization for illness. [s. 6. (10) (b)]

13. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary.

During the inspection, a door alarm was observed to be in place and operational on a resident door.

The health care records for this resident were reviewed for information regarding the use of a door alarm on the door to the resident's room. There was no reference to the use of a door alarm in the current plan of care. The Treatment Administration Record (TAR) included a space for the registered staff to initial every eight hours to acknowledge the use of the door alarm.

An interview was conducted with S #105 and S #102 and they identified that the door alarm was no longer required.

The plan of care for this resident was not reviewed and revised when their care needs changed and the care set out in the plan was no longer necessary, specifically, a door alarm on the resident's door was no longer required. [s. 6. (10) (b)]

14. The licensee has failed to ensure that the resident is reassessed and the plan of care

reviewed and revised at least every six months and at any other time when, (b) the resident’s care needs change or care set out in the plan is no longer necessary.

Resident #001 was observed, and throughout the inspection, seated in a specialized chair with a restraint in place, attached at the back of the chair with a clip release. There was no seat belt in place across the resident's waist, no table tray, and no geri-chair in use.

The progress notes were reviewed and included reference to a high risk for falls and attempts to get out of the wheelchair.

An interview was conducted with S #105 and they reported that resident #001 currently uses a specialized chair with a specific type of restraint, they do not have a seat belt, nor tray table or geri chair.

An interview was conducted with S #108 and they reported that resident #001 used to slouch down in their chair, too much pressure and they slid down in the chair and now has a specific type of restraint in place.

The current care plan under the problem of "Physical Restraint - PASD" includes the intervention of seat belt, geri chair, tray table and tilt recline chair. Under the problem of "Risk of Injury from falls" it notes the use of "chair that prevents rising", "ensure that (resident #001) seat belt is on" and "ensure both side rails are up while in bed".

Resident #001's plan of care was not reviewed and revised when their care needs changed and the care set out in the plan was no longer necessary, specifically, a seat belt, tray table or geri-chair were not currently in use or required. [s. 6. (10) (b)]

15. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident’s care needs change or care set out in the plan is no longer necessary.

Resident #004 was observed seated in a specialized chair with a specific type of restraint attached at the back of the chair.

The current care plan with a problem focus of "ADL assistance" was reviewed and included the use of a "geri-chair with traytable", the "Activation Care plan", included the intervention of "Escort (resident #004) to activity by walking (them) to area right from

point A to B as (they) will veer off and not attend" yet as reported by S #110 the resident couldn't walk.

An interview was conducted with S #105 and they reported that a table tray is no longer used for resident #004 and a specific type of restraint is used instead.

An interview was conducted with S #110 and they reported that resident #004 at one time had a tray table on the geri-chair and that resident #004 "couldn't really walk", therefore a specific restraint was used to keep them safe.

The care plan had not been updated to reflect resident #004's change in care needs, specifically, a table tray was no longer used and the resident no longer walked.

Previous non-compliance was identified from the RQI conducted February 18, 2014. Inspection report 2014_211106_0006 Compliance Order LTCHA 2007,c.8,s.6.(7) WN/VPC s.6.(1)(c) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 007 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. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

On a particular day in April 2015, Inspector #577 spoke with resident #014's spouse, and they had reported that minced food for the residents aren't consistently served in a minced texture. In addition, they reported that they had reported this on two occasions to the home's Administrator. An example was provided, they were feeding their family member a minced beef sandwich and found a large piece of formed beef, approximate 3 inches in length. On another day in April 2015, Inspector #577 was approached by this same family member, and was shown a formed piece of chicken, approximately 3 inches in length and 2 inches in diameter. They reported this piece of formed meat was found in resident #014's pureed meal four days ago, on the week-end. Inspector reviewed resident #014's plan of care, and it indicated that the resident is on a special diet that includes minced textures.

During the inspection, on a particular day, the provision of meals was observed during the lunch service and three plates of minced diets did not contain food with a consistent minced texture. A formed piece of fried beef, approximately 5cm in length and diameter was observed on one plate, and two other plates had green beans that were still formed and not in a minced texture. Inspector confirmed this consistency with Dietary Aide S #117, and S #113, and the registered staff S #103 was informed.

Inspector #577 met with S #128 and discussed concerns with minced diets not being consistently served in that texture. They reported a hand blender is used to mince food and further reported they were unaware of concerns about diet textures.

The licensee did not ensure that residents were provided with food and fluids that are safe, adequate in quantity, nutritious and varied, specifically for those residents assessed as requiring a minced texture diet.

Previous non-compliance was identified from the RQI conducted February 18, 2014. Inspection report 2014_211106_0006
LTCHA 2007,c.8,s.11.(2) WN/VPC [s. 11. (2)]

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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

The meal and snacks times as posted in the servery read "10 a.m. juice". The Resident Admission Handbook was reviewed and also indicated "Beverage 10:00 a.m.".

On a particular day during the inspection, the provision of a between meal beverage in the morning was not observed to take place. An interview was conducted with S #115 confirmed that no beverages were offered between breakfast and lunch on any days. They also reported that if requested, staff will provide a beverage to a resident and the nurses give water with pills. An interview was then conducted with S #113 and they reported that the kitchen staff gives the morning snack and beverage, nursing gives extra fluids in the morning, separate from the medication pass. S #113 clarified they "thought" the kitchen staff only gives morning snack to residents in the front television room.

The "Food and Nourishment Daily Record" for residents #026 and #027 was reviewed. The mid-morning nourishment "fluids taken" for resident #026 was noted on three of 30

days and resident #027's mid-morning nourishment "fluids taken" was noted one of 30 days. [s. 71. (3) (b)]

2. The licensee failed to ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

An interview was conducted with S #112 and S #102 and they reported that beverages aren't given on day shift, and further reported they are given at 1500hrs and later in evening.

The licensee failed to provide between-meal beverages in the morning and afternoon. [s. 71. (3) (b)]

3. The licensee has failed to ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

The snack pass was observed in the afternoon of a particular day during the inspection, and S #110 was seen to go past resident #001's room and not enter to offer the resident a snack or beverage. An interview was then conducted with S #110 and they reported that resident #001 was to receive a nutritional supplement at afternoon snack time but it was not provided as the resident was too tired and it would just be given at HS if they were sleeping in the afternoon.

On a particular day, during the inspection, resident #001 was not offered a between-meal beverage in the afternoon. [s. 71. (3) (b)]

4. The licensee has failed to ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening.

The snack pass was observed in the afternoon of a particular day, during the inspection, and S #110 was seen to go past resident #001's room and not enter to offer the resident a snack or beverage. An interview was then conducted with S #110 and they reported that resident #001 was to receive a nutritional supplement at afternoon snack time but it

was not provided as the resident was too tired and it would just be given at HS if they were sleeping in the afternoon.

The health care records for resident #001 were reviewed and the nutritional risk assessment identified them as being a high nutritional risk with a history of 9.5% loss of body weight over a specific time period. In addition, S #116 reported in an interview, that the nutritional assessment noted that this resident's energy requirements were not being met and upon review by the RD, it was determined that the nutritional supplement had not been given despite being ordered to start twice daily in December 2014.

Resident #001 was not offered a snack in the afternoon, specifically a nutritional supplement, despite being a high nutritional risk. [s. 71. (3) (b)]

Previous non-compliance was identified from the RQI conducted February 18, 2014. Inspection report 2014_211106_0006
WN/VPC O.Reg.79/10,s.71.(3)(c)

5. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

On a particular day, during the inspection, Inspector #577 observed the food preparation for dinner, and noted that the food choices were beef and chicken. Dietary Aide S #117 and S #113 both reported that chicken would not be available as pureed consistency. Inspector further confirmed that the home did not have enough pureed potatoes to serve residents.

On another day, during lunch hour, Inspector #577 observed the food preparation during dining, and noted that the food choices were corned beef sandwich and chicken fingers. Dietary Aide S #129 confirmed that chicken would not be offered pureed. Inspector #577 informed the Food Service Supervisor S #128 and they confirmed that two choices were not being offered at lunch and further reported to inspectors #196 and #577 that they weren't aware of this occurring and that staff are supposed to be offering two pureed choices at meals. [s. 71. (4)]

6. The licensee has failed to ensure that the planned menu items are offered and

available at each meal and snack.

During the lunch service at 1200hrs, on a day during the inspection, the menu posted outside of the main dining room on the white board, included bean medley soup, entree of chicken stew or turkey sandwiches, dessert was listed as strawberry yogurt or fruit cocktail. The monthly menu posted outside the main dining room confirmed this same meal.

An interview was conducted with Dietary Aide S #115 and it was reported that bean medley soup was available in a regular texture and the pureed soup was chicken noodle. The Dietary Aide was unsure why a different kind of soup was provided in the pureed form and not as posted on the menu. In addition, strawberry yogurt was not provided for dessert as was posted on the menu.

Later that day, the dinner menu posted outside of the main dining room included chili, biscuit, pork chop, rice, peas, cherry strudel and apricots. After discussion with S #117, it was determined that the rice and the peas and carrots were not available in a pureed texture.

The planned lunch and dinner menu items, specifically, pureed texture of rice and peas and carrots and strawberry yogurt, were not available. [s. 71. (4)]

Previous non-compliance was identified from the RQI conducted February 18, 2014. Inspection report 2014_211106_0006
WN/VPC O.Reg.79/10,s.71.(4) [s. 71. (4)]

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

The O.Reg.79/10,s. 2.(1)(b) identifies "sexual abuse" to be "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

The health care records for resident #001 were reviewed for information regarding responsive behaviours. The progress notes, over an approximate two month period, identified several incidents of sexual abuse by resident #001 towards other residents in the home.

An interview was conducted with S #100 and they reported that resident #001 did have sexual behaviours in the past, and stated "nothing too serious". Direct care staff members that were interviewed also reported a history of sexual behaviours towards female residents in the home and provided examples of incidents in which residents were sexually abused.

An interview was conducted with the District Manager/CEO S #101 and they reported that they were aware of some of the responsive behaviours of resident #001, but that the staff at the home had wanted the resident discharged from the home rather than deal with the behaviours. In addition, after discussion with S #101, it was determined that the incidents of sexual abuse towards female residents by resident #001 was not investigated and was not reported to the MOHLTC Director.

The care plan that was in effect at that time of these incidents for resident #001 was reviewed, and did not include strategies or interventions aimed at preventing incidents of sexual behaviours towards other residents in the home. [s. 19. (1)]

2. The licensee has failed to ensure that residents are not neglected by the licensee or staff.

A Critical Incident System report was submitted to the Director for an incident of alleged neglect of resident #015 by two staff members in the home. The home's investigation determined that S #121 and S #123, had neglected to check the safety and hygiene of resident #015 on a particular shift, which led to risk of harm.

During the inspection, the employee file for S #121 was reviewed and it identified a similar incident of neglect towards resident #015 which had been alleged to have occurred earlier that same month, by this same staff member.
An interview was conducted with S #120 and they reported that the incident which had occurred earlier that same month, had not been reported to the management of the home, District Manager/CEO and Human Resources, until approximately a week and a half after its occurrence. In addition, it was determined that the incident alleged to have occurred earlier in the month, had not been reported to the Director.

The licensee had been made aware of alleged neglect of resident #015 by S #121, yet they continued in their PSW position and a second incident of neglect had occurred later that same month, towards this same resident.

S #121 had been alleged to neglect resident #015 on a particular day, and it was not reported to the management of the home until one and a half weeks later. A second incident of neglect towards this same resident, by this same staff, occurred later that same month. [s. 19. (1)]

Additional Required Actions:

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

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 failed to ensure that 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: 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.

The O.Reg.79/10,s. 2.(1)(b) defines "sexual abuse" as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

The health care records for resident #001 were reviewed for information regarding responsive behaviours. The progress notes, over a two month period included several incidents of sexual behaviours towards other residents in the home.

An interview was conducted with the S #100 and they reported that resident #001 did have sexual behaviours in the past, and stated "nothing too serious". Direct care staff members that were interviewed also reported a history of sexual behaviours towards female residents in the home and provided examples of incidents in which residents were sexually abused.

An interview was conducted with S #101 and it was confirmed that the Director was not

notified of any of the incidents of sexual abuse towards female residents by resident #001 as they were resident to resident incidents. [s. 24. (1)]

2. The licensee failed to ensure that 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: 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.

A Critical Incident System report was submitted to the Director outlining an incident of alleged neglect of resident #015 that had occurred on a particular day. It was not reported to the Director immediately as required, and instead reported after the licensee's investigation had been concluded.[s. 24. (1)]

3. The licensee has failed to ensure that 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: 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.

During the inspection, the employee file for S #121 was reviewed and it included information that had been sent to S #101 and Human Resources. The information outlined an incident in which S #121 was alleged to have neglected resident #015, specifically, did not provide personal care, approximately one and a half weeks earlier.

An interview was conducted with S #120 and they reported that the incident which had occurred had not been reported to the Director immediately, nor was the incident reported to the Director at a later time. The licensee conducted an investigation into the reported incident as well as the incident that had occurred later that same month and subsequently terminated S #121 after determining that neglect had occurred on two separate occasions.

A separate incident of neglect towards a resident had occurred earlier in that same month, and it was not reported to Director. [s. 24. (1)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to 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.

During the inspection, resident #004 was observed in a specific type of chair with a restraint in place and attached at the back of the chair. According to S #110, resident #004 "can't really walk", so the restraint was used to keep them safe.

The health care records for resident #004 were reviewed. The "Personal Assistance Services Device Consent Form" was signed on admission by the SDM and witnessed by S #105 and identified the use of a seat belt, table tray, geriatric chair, tilt-recline chair, for

all shifts and contained pre-signed signatures of the Medical Director and the Administrator. According to S #105, these forms are signed on admission to the home for all residents.

An interview was conducted with S #105 and the "Personal Assistance Services Device Consent Form" for use of restraints was reviewed and a the type of restraint observed is use was not included for use on resident #004. S #104 also confirmed that an physician's order for the use of this specific type of restraint and consent from the SDM had not been obtained.

The current care plan with focus problem of "Physical Restraints-PASD" identified the use of a "trunk restraint" and "use of a chair that prevents rising".

Resident #004 was restrained by a physical device, a specific type of restraint, and the health care records did not contain a physician's order for this type of device. [s. 110. (2) 1.]

2. The licensee has failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Resident #001 was observed sitting in a wheelchair on a particular day during the inspection, with a restraint in place and attached at the back of the chair.

The "Northwood Lodge Hourly Monitoring Record" for a one month period was reviewed and it included a space for the registered staff to initial every eight hours to acknowledge that the resident's condition was reassessed and the effectiveness of the restraining was evaluated. On eighteen shifts out of a seven day period, the registered staff had not initialed.

An interview was conducted with registered staff S #102 and it was reported that the registered staff do not initial every eight hours to acknowledge the reassessment of restraint use on a resident.

An interview was conducted with registered staff S #104 and they reported that they don't

reassess the need for a restraint every eight hours, they will look at the resident, but do not reassess the continued need for the restraint or its effectiveness. In addition, it was reported that the PSW's are to check the restraint every hour, check for tightening, make sure resident's haven't taken them off, they are working properly, and that there is no injury to the resident.every hour, check for tightening, make sure resident's haven't taken them off, they are working properly, and that there is no injury to the resident.

Resident #001 was restrained by a physical device, and the resident's condition and the effectiveness of the restraining was not assessed by the registered nursing staff, at least every eight hours. [s. 110. (2) 6.]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

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 that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. [s. 73. (1) 5.]

On a particular day, during the inspection, S #115 provided a diet census list from the nourishment cart reportedly used by staff during afternoon snack pass. The census list indicated resident names, diet type, texture, "Other" (supplements, special preferences, allergies, dislikes), choking risk, tea/coffee. Two residents were identified, #026 and #027, as being on ordered fluid restrictions.

A review of resident #026's Nutritional Care plan, and diet census, both noted fluid restrictions of a specific amount in 24 hours. A review of Food and Nourishment Daily Record indicated that on 13 of 28 days, resident #026's documented fluid intake exceeded this amount in 24 hours.

A Review of resident #027's Nutritional Care plan, and diet census, both noted fluid restrictions of a specific amount in 24 hours. A review of Food and Nourishment Daily Record indicated that on 16 of 28 days, resident #027's documented fluid intake exceeded this amount in 24 hours.

There was no indication of ordered fluid restriction in the "comments about special needs" on the Food and Nourishment Daily Record for either resident #026 and #027.

As S #113 was starting the afternoon nourishment pass in the afternoon on a particular day, during the inspection, they were asked if there were any residents on fluid restrictions. S #113 reported there was no one on fluid restriction currently and they (staff) would receive that information during shift report.
In addition, it was reported if (residents) are on fluid restriction for a long time, it is on the memo board in the report room. The memo board in the report room had no reference to fluid restrictions ordered for residents #026 and #027.

Inspector #616 observed S #107 and S #113 as they continued with the nourishment pass. The inspector brought to their attention the fluid restrictions for both residents #026 and #027. S #107 stated they were not sure if both residents were still on restrictions, further adding they thought the residents might have "been taken off", and advised the inspector to ask the nurse. S #113 later clarified to the inspector they just noticed the clipboard on the nourishment cart that outlined diets but had not seen the clipboard before. At this time, S #107 confirmed the clipboard has been on the nourishment cart for the last few months however it was inconsistent depending on which kitchen staff was working. However, S #107 reported the diet census had been with the nourishment cart more consistently over the last few months. S #107 and #113 were unable to provide clear knowledge of residents on fluid restriction.

On another day, an additional form was observed at the servery counter "Dietary needs of all resident must be checked at time of meal". S #115 reported that it is the PSW's responsibility to sign off each meal. Review of this form, for one specific day, noted Breakfast and Lunch each checked for all residents whereas the supper column was unchecked for all residents. On another day, the noted columns for each Breakfast, Lunch and Supper were unchecked for all residents. On the date of review, each column for Breakfast and Lunch were unchecked for all residents at 1415hrs.

2. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

On a particular day during the inspection, the dietary reference sheet as was posted in the servery, was copied and reviewed for information regarding resident dietary requirements.

On this same day, resident #017 was observed to be assisted with their supper meal. S #109 was interviewed and they reported that the resident had juice and tea to drink. Dietary Aide S #117 was asked if a supplement was put into resident #017's food and they reported that it was not given, nor was the specified type of juice offered, despite the dietary reference sheet had it listed.

Resident #028 was observed with a glass of juice and the Dietary Aide S #017 reported that they were not provided with the type of juice as listed on the dietary reference sheet.

At this same meal, S #130 was observed to assist resident #007 with a bowl of apricots that had been cut into approximately 1cm X 1cm pieces, yet the dietary reference sheet identified a diet texture different than cut for foods.

Resident #018 was observed to eat cut up pieces of pork chop, in approximately 1cm X 1cm size, yet the dietary reference sheet identified a diet texture different than cut that was to be provided. The Dietary Aide S #117 was questioned and confirmed that a cut up pork chop had been provided to this resident.

Resident #015 was observed with silverware on the table in front of them, and included a

knife, fork and spoon. The dietary reference list read "no knives, plastic utensils". S #110 was questioned why the resident could not have silverware and they reported that it was because they used to walk away with these items, but they don't walk anymore.

Despite having a dietary reference sheet that was readily available to food service workers and other staff assisting residents, several residents were not provided with the correct diet textures, their preferences and the ordered recommendations on that particular day during the inspection. [s. 73. (1) 5.]

3. The licensee has failed to 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.

Resident #017 was seated in the common room and a plate of pureed food was placed on the table in front of them by Dietary Aide S #117 at 1709hrs. S #110 was observed to assist resident #017 with their meal at 1715hrs, after this staff had finished assisting two other residents at a different table.

On this particular day, during the inspection, a meal was placed on the table in front of resident #017, yet a staff member was not available to assist the resident at that time. [s. 73. (2) (b)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 71. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the long-term care home has a Director of Nursing and Personal Care. 2007, c. 8, s. 71. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the long-term care home has a Director of Nursing and Personal Care.

On April 22, 2015, a photocopy of the newspaper advertisement for the local newspaper, was provided to the Inspector, to demonstrate the licensee's active recruitment for a Director of Nursing for Northwood Lodge.

The long-term care home has not had a Director of Nursing (DON), working on site at the home since November 5, 2014. (196)

2. The licensee has failed to ensure that the long-term care home has a Director of Nursing and Personal Care.

During the inspection, Inspector #577 and #196 met with S #100 who reported that the home has not employed a Director of Nursing since November 6, 2014. The previous Director of Nursing (DON), S #122, left the position in September 2014 and then S #119 took on the role of DON through to November 5, 2014. [s. 71. (1)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

The written policy ADM 450 titled "Zero Tolerance of Abuse/or Neglect" with revision date

of 09/14, as provided by S #105, was reviewed for the required information. The written policy identified that "sexual abuse" means "any nonconsensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member" as is in O.Reg.79/10,s.2(1), and the policy included information on the the duty to make mandatory reports as in the LTCHA 2007,c.8,s.24.(1).

However, despite having this written policy to promote zero tolerance of abuse and neglect, the incidents of sexual abuse that had occurred over an approximate two month time period, in 2014, by resident #001 towards residents in the home, had not been reported to the Director. In addition, the incidents were not investigated, nor was the SDM of resident #016 notified.

The home did not comply with their own written policy to promote zero tolerance of abuse and neglect of residents. [s. 20. (1)]

2. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

On a particular day in 2014, management was made aware of an incident in which S #121 was alleged to have neglected resident #015, specifically, did not provide personal care, on an earlier day in 2014. The licensee's written policy to promote zero tolerance of abuse and neglect of residents states that "neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O.Reg.79/10,s.5.".

The licensee's written policy reads, under "Mandatory Reporting under the LTCHA", that an immediate report to the MOHLTC Director where there is a reasonable suspicion that the following incidents occurred or may occur: 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.

An interview was conducted with S #120 on and it was confirmed with the inspector that the incident of neglect, alleged to have occurred on that day in 2014 was never reported to the Director. Secondly, a Critical Incident System report was submitted to the Director in 2014 for an incident of neglect from two staff members, S #121 and S #123 towards

resident #015. An after hours pager call was not initiated by the licensee, nor was the Director notified immediately of the alleged incident of neglect and instead was notified after the licensee had conducted their investigation into the allegation of neglect.

An incident which had occurred in 2014, was never reported to the Director and the incident of neglect which had occurred on another day in 2014, was not reported immediately, but five days afterwards. The home did not comply with their own written policy to promote zero tolerance of abuse and neglect of residents. [s. 20. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, the following are developed to meet the needs of residents with responsive behaviours: 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Inspector #616 reviewed the progress notes related to behaviours for resident #025 for a one month time period and there was evidence of activity involving safety concerns.

The progress notes for (resident #025)included a note that the resident had attempted to drink hand sanitizer. Earlier this same day, Inspector #616 also observed resident #025 attempting to pour hand sanitizer into a half full glass of water at the nursing station and notified staff at that time.

Resident #025 care plan review indicated impaired communication related to problem understanding others . Intervention noted in Behaviour Problem/Mood State care plan is to "state clearly to resident #025 " This behaviour is not acceptable, please stop".

Inspector #616 spoke with S #102 regarding resident #025 behaviours and they reported that at a particular time of the day the resident has more difficulty and that the communication method for sharing a resident's behaviour triggers or interventions is by charting on the computer, or on the white board in report room. In addition, S #102 reported that resident #025 liked to be busy, with actions having purpose generally.

Inspector #616 spoke with S #114 regarding the activation care plan as finding none in resident #025 health record. S #114 reported maintains binder for all Activation Care plans separate from the residents health records and the admission assessment is currently incomplete.

Resident #025 had been demonstrating responsive behaviours, and the care plan did not include strategies aimed as responding to these behaviours.[s. 53. (1) 2.]

2. The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviours: 3. Resident monitoring and internal reporting protocols.

The care plan for resident #025 was reviewed for reference to, and staff monitoring of the resident with a specific safety intervention in place. There was no reference to the use of this intervention for this resident. S #102 was unable to provide a clear answer when asked if this specific safety intervention requires monitoring by staff.

An interview was conducted with S #100, regarding the process for monitoring the specific safety intervention for resident #025 and it was reported that they were unable to verify whose responsibility (PSWs or nurses) to check placement of the intervention each shift, and stated that when it alerts, at an exit, staff go check the door. In addition, S #100 was unable to verify the process of monitoring the resident with this specific safety intervention in place and stated "I think they just tell the nurses" and further reported there is no signing sheet, and they did not make up a record for staff to document monitoring [s. 53. (1) 3.]

3. The licensee has failed to ensure that for each resident demonstrating responsive

behaviours, (b) strategies are developed and implemented to respond to these behaviours, where possible.

The health care records for resident #001 were reviewed for information regarding responsive behaviours. The progress notes, over an approximate two month period, identified several incidents of sexual abuse by resident #001 towards other residents in the home. An interview was conducted with S #100 and they reported that resident #001 did have sexual behaviours in the past, and stated "nothing too serious". Direct care staff members that were interviewed also reported a history of sexual behaviours towards female residents in the home and provided examples of incidents in which residents were sexually abused.

An interview was conducted with the District Manager/CEO S #101 and they reported that they were aware of some of the behaviours of resident #001, but that the staff at the home had wanted the resident discharged from the home rather than deal with the behaviours.

An interview was conducted with S #110 and they reported that resident #001 no longer had behaviours. S #108 reported that resident #001 used to have some sexual behaviours with other residents. The female residents, some of which remain unidentified, were not protected by the home from incidents of sexual abuse from resident #001.

The care plan, in effect at the time of these incidents, under the focus of "Behavior problem" and "sexually inappropriate" was reviewed. The plan did not include strategies aimed at minimizing these responsive behaviours, specifically sexually inappropriate behaviours. [s. 53. (4) (b)]

4. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours.

Inspector #616 reviewed the progress notes related to behaviours for resident #025 for a one month time period and there was evidence of activity involving safety concerns. The progress notes for (resident #025) included a note that the resident had attempted to drink hand sanitizer. Earlier this same day, Inspector #616 also observed resident #025 attempting to pour hand sanitizer into a half full glass of water at the nursing station and notified staff at that time.

Resident #025 care plan review indicated impaired communication related to problem understanding others . Intervention noted in Behaviour Problem/Mood State care plan is to "state clearly to resident #025 " This behaviour is not acceptable, please stop".

Inspector #616 spoke with S #102 regarding resident #025 behaviours and they reported that at a particular time of the day the resident has more difficulty and that the communication method for sharing a resident's behaviour triggers or interventions is by charting on the computer, or on the white board in report room. In addition, S #102 reported that resident #025 liked to be busy, with actions having purpose generally.

Inspector #616 spoke with S #114 regarding the activation care plan as finding none in resident #025 health record. S #114 reported maintains binder for all Activation Care plans separate from the residents health records and the admission assessment is currently incomplete.

Resident #025 had been demonstrating responsive behaviours, and the care plan did not include strategies aimed as responding to these behaviours. [s. 53. (4) (b)]

Additional Required Actions:

CO # - 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

Fire extinguishers outside of two resident rooms, were observed to be unsecured on shelves in the corridor of the home.

S #124 was informed that these two fire extinguishers were unsecured on shelves in the corridor of the home and they reported that they would be checked.

S #100 was informed of the concern for resident safety of these two fire extinguishers were unsecured on shelves in the corridor of the home and residents may remove and injure themselves or others. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the home is a safe and secure environment for its residents, specifically, that the fire extinguishers are secured on shelves in the resident corridors, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

An interview was conducted with S #119 and they reported that the bed systems are not evaluated at Northwood Lodge, the beds are due for replacement and entrapment zone testing has not been done. In addition, it was reported that the maintenance staff that work at the home, are from the hospital site and are not familiar with the requirements and therefore testing on the beds is not done. [s. 15. (1) (a)]

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

Inspector #577 observed to full bed rails to be elevated for resident #012. During an interview with S #119 and S #101, they reported the residents' beds in the home are 15 years old, and are due for replacement. They further reported that they do not use any tools to test for zones of entrapment. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The progress notes for resident #025 were reviewed and included three entries related to windows in the home and safety concerns.

Inspector #616 confirmed that resident #025's room window handles had been removed. Further observation of one particular resident room, which is representative of the windows throughout the resident home areas: divided into 4 quarters with the 2 upper quarters screened (24" x24" or 60.96 cm x 60.96 cm) with crank to open each section. 2 lower quarters are glass, no opening. At base of window is ledge 17" (43.18 cm) wide.

The opening of the window near the entrance to the home was measured to be 26 centimetres when open.

There was no reference in resident #025's plan of care regarding potential window safety. [s. 16.]

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 that ensures every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that (b) is on at all times.

On a particular day, during the inspection, Inspector #196 tested the bedside call bell in resident #004's room and determined it was not functioning. In addition, Inspector #196 tested the bedside call bell in resident #005's room and determined it was not functioning.

These non-functioning call bells were brought to the attention of the PSW working on that side of the unit, and subsequently S #124 attended and repaired the call bells at that time. [s. 17. (1) (b)]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that (d) is available at each bed, toilet, bath and shower location used by residents.

On a particular day, during the inspection, Inspector #196 observed a resident washroom, and the call bell did not have a pull cord in place for the resident to access the resident-staff communication and response system.

This was brought to the attention of the PSW working on that side of the unit, and subsequently S #124 attended and replaced the pull cord at that time. [s. 17. (1) (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 that ensures that the home is equipped with a resident-staff communication and response system that (b) is on at all times and is available at each bed, toilet, bath and shower location used by residents, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone.

The O.Reg.79/10,s. 2.(1)(b) defines "sexual abuse" as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

The health care records for resident #001 were reviewed for information regarding responsive behaviours. The progress notes, over an approximate two month time period, included several incidents of sexual behaviours towards other residents in the home.

An interview was conducted with S #100 and they reported that resident #001 did have sexual behaviours in the past, and stated "nothing too serious". Direct care staff members that were interviewed also reported a history of sexual behaviours towards female residents in the home and provided examples of incidents in which residents were sexually abused.

An interview was conducted with the District Manager/CEO S #101 and it was confirmed that the Director was not notified of any of the incidents of sexual abuse towards female residents by resident #001 as they were resident to resident incidents. In addition, when questioned about the investigation of these sexual abuse incidents, they reported that if the current site Administrator, S #100, did not have any notes on the investigation then there may not be any investigation notes. S #100 did not have any record of investigation or notes when asked by Inspector #196. [s. 23. (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 that ensures that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

On a particular day, during the inspection, S #100 provided Inspector #616 with CCAC (Community Care Access Centre) recommendations that had been received by S #100 regarding the behavioural referral for resident #025. Inspector interviewed S #104 who confirmed the recommendations were provided but was instructed to file it in the resident's hard copy of chart.

At the time of inspection and interview with S #104, there was no indication the interdisciplinary report including the initiation of DOS monitoring as recommended, was incorporated into resident #025's plan of care. [s. 26. (3) 5.]

2. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The health care records for resident #001 was reviewed for information regarding responsive behaviours, specifically sexual behaviours. The progress notes as found online, for an approximate time period of two months, identified several incidents in which resident #001 had demonstrated sexual behaviour towards other residents in the home. The care plan that was in effect at the time of these incidents was reviewed and included reference to sexually inappropriate behaviours and wandering, but did not include any triggers or interventions aimed at reducing the behaviours or protecting other residents. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #17: 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 that the staffing plan, (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.

An interview was conducted with S #100 concerning the staff shortages for Personal Support Workers (PSW) for February and March 2015. They reported that for the month of February 2015, the staff worked short nine shifts and for the month of March 2015 they worked short eight shifts.

The home's staffing plan, titled 'Staffing Plan' for Pinecrest, Princess Court and Northwood Lodge, policy number ADM 235 was obtained from S #110 and was reviewed. The policy did not contain a back-up plan and listed the staffing quota for unit 1, unit 2, unit 3, and unit 4. Staffing complement for home is unclear, as home has only one unit.

On one particular day, during the inspection, the home was short staffed by 2 PSW's, and S #102 confirmed that five residents did not receive their tub baths.

On the following day, the home was short staffed by one PSW, and S #108 confirmed that five residents did not receive their tub baths.

An interview was conducted with S #119 and S #101 and they reported that they do not have a staffing back up plan for Northwood Lodge. [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 that ensures that the staffing plan, (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, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During the inspection, resident #003 reported to Inspector #196 that they did not receive a shower that day, as the home was short staffed.

Inspector #577 reviewed the home's weekly bath schedule and bath assessment sheets. The bath schedule indicated that resident #003 is scheduled for a bath every Tuesday and Friday. Upon further record review of bath assessment sheets, resident #003 had not received a bath/shower on four assigned days that month.

An interview was conducted with S #102 regarding staffing for that day, and they reported that the home was short staffed by two PSW's, one PSW is working. At 1400hrs, further discussion took place with S #102 to inquire about any missed resident care. They reported that scheduled baths and nail care and (shaving if applicable), for five residents #028, #029, #019, #020 and #026 had not been done. S #112 confirmed that the five scheduled baths were not done.

On another day, an interview was conducted with S #108 and they reported that the home was short one PSW and confirmed that scheduled resident baths for resident #027, #022, #021, #002 and #011 would not be done today and would be 'skipped'.

The resident's bath assessment records were reviewed and indicated `no shower-working short` for resident #028 on one day, `short staffed-no bath`for resident #022 and #002 on another day, during the time of inspection.

An interview was conducted with S #112 and inquired about residents who miss their

bath/shower when the home is short staffed, and they reported that it would be a 'missed' bath for the week. Inspector reviewed the bath assessment records for those same two days and further confirmed that those ten residents did not receive their bath/shower on days or evening shift.

During a discussion with S #100, the inspector inquired about residents missing their baths due to home being short staffed and they reported that they are trying to schedule an extra staff member this weekend for resident baths.

The home failed to ensure that residents receive a bath twice a week, due to insufficient staffing, on seven specific days. [s. 33. (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 that ensures that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (1) The skin and wound care program must, at a minimum, provide for the following:
4. Treatments and interventions, including physiotherapy and nutrition care. O. Reg. 79/10, s. 50 (1).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that skin and wound care program must, at a minimum, provide for the following: 4. Treatments and interventions, including physiotherapy and nutrition care.

Resident #001 had altered skin integrity as documented in a wound care consultation note completed by the RN EC in January 2015.

It was determined during an interview with the site Administrator S #101, that physiotherapy services had not been provided in the home since February 14, 2014, and has only recently started physiotherapy assessments via web cam.

Physiotherapy care had not been provided to resident #001, as part of the skin and wound care program, as this service was not available in the home. [s. 50. (1) 4.]

2. The licensee has failed to ensure that (c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

Resident #001 had developed altered skin integrity as documented in a wound care consultation note completed by the RN EC in January 2015. In the note, recommendations were made that included the use of a pressure relieving device. A further wound consultation note done approximately four months later, identified that the wound was still present.

During the inspection, the recommended pressure relieving device was not in use for resident #001 as confirmed by S #105 and they reported that the home did have a device, but it was broken and they were trying to get one for the home but it was very expensive.

An interview was conducted with the site Administrator S #100 and it was reported that they were aware of the recommendation made by the RN EC for the use of a pressure relieving device in January 2015 for resident #001. However, they indicated that there had been a flood in the basement and the device needed to be checked, and this was something they had been working on.

Resident #001 was not provided with a pressure relieving device, as recommended, as there was not one available for use at the home. [s. 50. (2) (c)]

3. The licensee has failed to ensure that (d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

Inspector reviewed resident #013's care plan, which identified the resident's continence status and interventions included a toileting routine and repositioning. According to the care plan, resident #013 was at risk for skin breakdown due to continence status and medical conditions.

On a particular day, during the inspection, resident #013 was observed at 1100hrs, 1200hrs, 1300hrs and 1400hrs, to be seated up in a specialized wheelchair in the same position, and not re-positioned by staff. Inspector interviewed S # 112 at 1415hrs that same day, who confirmed that resident #013 had not been toileted or re-positioned, since getting up in their wheelchair at 0700hr.

On another day, resident #013 was observed at 0915hrs, 1100hrs, and 1200hrs, to be

seated up in a specialized wheelchair in the same position, and not re-positioned by staff. Inspector spoke with S #108 and they reported that resident #013 was repositioned, the incontinent product was changed and put back to bed at 1330hrs. Inspector further spoke with S #100 and inquired about their expectations concerning repositioning residents that are in wheelchairs and cannot reposition themselves. They reported that their expectation is that residents will be repositioned after breakfast 1000hrs, after lunch and also at 1400hrs. [s. 50. (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 that ensures that the skin and wound care program provides for treatments and interventions, including physiotherapy, that equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing and any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that (c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

During the inspection, it was reported to Inspector #196 that resident #004 is often put into a specialized chair for long periods as staff are too busy for them.

The care plan for resident #004 was reviewed and indicated how staff are to assist with toileting, incontinence care, hygiene care, product use, transfer needs and ambulatory status.

On a particular day, during the course of inspection, resident #004 was observed on five occurrences through out the day and their positioning and location was noted.

Later that same day, S #112 was questioned regarding the toileting needs of resident #004. They reported that they tried to toilet the resident at a specific time without success and put them into bed before lunch to assist with continence care.

During the course of the inspection, resident #004 was observed to be non-ambulatory and secured in a specialized chair or in their bed.

An interview was conducted with S #100 and inquired about their expectations concerning repositioning and toileting residents that are in wheelchairs and cannot reposition themselves. They reported that their expectation is that residents will be repositioned and toileted after breakfast 1000hrs, after lunch and also at 1400hrs.

The licensee failed to ensure resident #004 who is dependent on staff for toileting, received the assistance they needed to maintain continence. [s. 51. (2) (c)]

2. The licensee has failed to ensure that (g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable.

On a particular day, during the inspection, resident #013 was observed to be lying in their bed after lunch, and a strong smell of urine was noted.

The care plan for resident #013 was reviewed and it indicated the continence status for the resident and included interventions for continence and skin care, toileting schedule and repositioning in their chair.

On a particular day, during the inspection, resident #013 was observed at 1100hrs, 1200hrs, 1300hrs and 1400hrs, to be seated up in a specialized chair in the same position, and not re-positioned by staff or toileted. S #112 confirmed that resident #013 had not been toileted today, since 0700hrs.

On another day, resident #013 was observed at 0915hrs, 1100hrs, and 1200hrs, to be seated up in a specialized chair in the same position, and not re-positioned by staff or toileted. S #108 reported that resident #013 was repositioned, their incontinent product was changed and then was put back to bed at 1330hrs. Inspector further spoke with S #100 and inquired about their expectations concerning repositioning and toileting residents that are dependent on staff and cannot reposition themselves. They reported that their expectation is that residents will be repositioned and toileted after breakfast 1000hrs, after lunch and also at 1400hrs.

Resident #013, who is dependent on staff for toileting, did not receive the assistance they required to maintain continence and remain dry and comfortable. [s. 51. (2) (g)]

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 that ensures each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence and residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that (b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident.

Inspector #616 spoke with S #111 regarding staff communication, relating to resident specific requirements or changes and they stated information regarding residents occurs at shift change through taped report. Inspector #616 inquired whether they had knowledge of resident #025's safety intervention and they confirmed they did but was unsure if it was still in place. When asked what was shared at shift report, S #111 indicated there was no communication today at report with respect to the removal of the safety intervention for resident #025's.

Review of the home's Responsive Behaviour Program (Policy Number:NUR 445, dated 01/13) under "Monitoring and Communication" reads: "All staff should be informed at the beginning of each shift when residents require heightened monitoring. Any new responsive behaviours and any behaviours that may cause risk to the resident or others should also be communicated to staff". [s. 55. (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 that ensures that all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others, to be implemented voluntarily.

WN #22: 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 that that the nutritional program included, (e) a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter.

Upon review of the health care records for resident #001, it was determined that the weights for two months over the past year had not been recorded. The most recent nutritional assessment identified the resident to be at high risk. In addition, resident #001, had a significant weight loss since admission to the home.

An interview was conducted with the RD and they confirmed that these weights from two specific months were missing from the records and that there had been a concern with having the monthly weights done and documented.

Resident #001 did not have monthly weights recorded for two specific months, despite being identified as a high nutritional risk and for having lost a significant amount of weight since admission. [s. 68. (2) (e) (i)]

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 that ensures that the nutritional program includes a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions.

On a particular day, during the course of inspection, at 1200hrs, the menu posted on the white board outside the main dining room included bean medley soup and strawberry yogurt.
The meal selections were discussed with dietary aide S #115 and it was reported that the bean medley soup was not available in a pureed texture and instead was substituted with chicken noodle. In addition, strawberry yogurt was not provided to the residents as posted on the menu, but raspberry square and fruit cocktail was. The dietary aide was unsure why a different kind of soup was provided in a pureed form and not the soup as posted in the menu.

Later that same day, at 1705hrs, the dinner menu written on a white board outside the main dining room, listed chili, biscuit, pork chop, rice, peas, cherry strudel and apricots and this menu correlated with the posted monthly schedule.

An interview was conducted with Dietary Aide S #117 regarding the available menu items. They reported that neither rice nor biscuits were available in a pureed texture for residents requiring a pureed texture diet and instead mashed potatoes were to be given.

The residents requiring a pureed textured diet on a specific day, at lunch and dinner, were not made aware of the menu substitutions, specifically, the provision of chicken noodle instead of bean medley soup and mashed potatoes instead of rice and biscuit. [s. 72. (2) (f)]

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 that ensures that the food production system provides for, communication to residents and staff of any menu substitutions, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

A resident census list was provided at the time of inspection and it identified thirty-two occupied beds.

An interview was conducted with the RD S #116 and it was reported that they are on site at the home to provide clinical and nutrition care duties for the residents of the home, every two months for a total of thirty-two hours.

It was reported by S #120, that the registered dietitian (RD) is on site at the home on a bi-monthly basis for four days totaling thirty-two hours, fulfilling the requirement of sixteen hours per month.

The RD is not on site for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties and instead attends the home on a bi-monthly basis. [s. 74. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #25: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

S #121 and S #123 were both investigated by the licensee and deemed to have neglected to provide care to resident #015 during a shift.

During an interview with S #100, they could not confirm, nor did they have training records for S #121 and S #123 regarding the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (2) 3.]

2. The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 4. The duty under section 24 to make mandatory reports.

An interview was conducted with S #100, and it was reported that they had started in the role of site Administrator at the home in November 2014 and had received online training and also had received training with S #119 and that they would let the manager know of any concerns. When questioned regarding mandatory reporting to the Director under section 24, they reported that they would have to have a look at the list of things that had to be reported as it was not memorized but thought that resident death, staffing concerns that result in dismissal, abuse, behaviours with consequences, misconduct with residents, were to be reported. [s. 76. (2) 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 that ensures that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents and The duty under section 24 to make mandatory reports, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The progress notes of resident #001 were reviewed for information regarding responsive behaviours. The notes on two separate days, just over a month apart, had identified two separate incidents in which resident #016 had been sexually abused by resident #001.

The progress notes of resident #016 were reviewed and did not identify that the SDM was informed of either incident.

An interview was conducted with District Manager/CEO S #101 and they could not confirm if the SDM of resident #016 was notified of the first incident that had occurred, nor the incident that had occurred on a later date. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital.

The health care records for resident #005 were reviewed. The progress notes indicated that on a particular day, this resident had a fall with injury and taken to hospital.

Inspector #577 spoke with S #100 and they reported that they were not aware of resident #005 falling and having an injury. They further reported that the incident was not reported to the Director.

Resident #005 had a fall, which resulted in being taken to the hospital and treated for an injury, and the incident was not reported to the Director. [s. 107. (3) 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 that ensures that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital, to be implemented voluntarily.

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that prohibited devices that limit movement, and device with locks that can only be released by a separate device, such as a key or magnet are not used in the home.

Progress notes for resident #001 were reviewed for information regarding responsive behaviours. A note made on a particular date, entered by S #102, identified the use of a prohibited device for this resident.

A telephone interview was conducted with S #102 and it was confirmed that a prohibited device was used on resident #001, but they are not used any more and they haven't seen one in the home since that time. [s. 112.]

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 that ensures that prohibited devices that limit movement, and device with locks that can only be released by a separate device, such as a key or magnet are not used in the home, to be implemented voluntarily.

WN #29: 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 ensure that (a) drugs are stored in an area or a medication cart, (iv) that complies with manufacturer's instructions for the storage of the drugs.

During the inspection, the emergency drug supply drawer in the medication room had a bottle of Nitrostat spray .3 mg s/l that had a manufacturer's expiry date of October 2014.

This manufacturer's instructions for storage of this prescription medication was not complied with, specifically, it had passed it's expiry date. [s. 129. (1) (a)]

2. The licensee has failed to ensure that (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.

During the inspection, a review of the medication cart was conducted and a controlled substance was found in resident #013's medication roll and, the medication roll for resident #017 contained a different controlled substance.

These controlled substances were not stored in a separate, double locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart . [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that drugs are stored in an area or a medication cart, (iv) that complies with manufacturer's instructions for the storage of the drugs and that 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, to be implemented voluntarily.

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. 2.

A review of the Responsive Behaviour Program, Policy Number: NUR 445 (01/13) reads under "Orientation and Training: All staff, contractors providing direct care and volunteers must be oriented prior to assuming their job responsibilities and retrained annually in caring for persons with responsive behaviours and behavior management".

During the inspection, Inspector #616 interviewed S #111 regarding their training/education related to responsive behaviours and they recalled attending CPI (Crisis Prevention Intervention) training a "few years back".

In response to Inspector #616's request for verification of staff education related to responsive behaviour training within the last year, S #100 provided documentation that a total of four (two PSWs, one RPN and one Dietary staff) of approximately 27 Full-time/Part-time direct care staff attended a training session on crisis prevention intervention in August 2014. [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act, to be implemented voluntarily.

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the inspection, at 1650hrs on a particular day, S #103 was observed administering medications to residents in the home.

During the administration of medication to resident #001, one tablet of medication was removed from a stock bottle in the cart and put into the nurse's hand and then placed into a pouch with their other medications and then crushed. Following the administration of the crushed medications to this resident, the staff member proceeded to take a tablet out of a different bottle and again put it into their hand and cut it in half for a different resident. Hand hygiene was not observed to be performed during the medication administration between residents.

A test for resident #009 was then performed at the table in the common dining room and then an injection was prepared and administered and hand hygiene was again not observed to be performed between resident medication administration.

This staff member did not participate in the implementation of the infection prevention and control program, in that they did not perform hand hygiene between residents during the administration of medications. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #32: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On a particular day, during the inspection, at 1720hrs, resident #002 was observed to be served a plate of food upon being seated at their table and an entree meal choice was not offered. At this same time, S #118 Dietary Aide, was observed serving resident meals as per a list that had resident choices written on it. S #109 confirmed to the inspector that residents on a specific textured diet are not given a entree meal choice.

On another day, at 1705hrs, Inspector #196 observed Dietary Aide S #117 place pre-packaged pureed texture foods and put on plates for those residents requiring this texture diet. The food was not separated, meat, potatoes and vegetables, but mixed together. Puree consisted of pork, potatoes and carrots in the cardboard container.

On another day, at 1215hrs, S #114 was observed to go around the main dining room with a show plate and ask residents which entree they would like for lunch. This staff member was then asked why resident #015 was not shown a show plate, nor asked what they would like to eat. It was confirmed that since this resident was on a specific textured diet they were not offered a meal choice. [s. 3. (1) 1.]

WN #33: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items; O. Reg. 79/10, s. 37 (1).

During a tour of the home, Inspector #577 found a plastic bin in home's tub room with 2 unlabelled brushes and 2 unlabelled combs. Brushes and combs appeared unclean, with hair attached. Beside the bin was a sign that read, 'No personal care products-including combs and brushes are to be shared between residents, no personal items are to be kept in tub room, all personal products must be returned to residents room after use'. Inspector spoke with S # 108, and showed them the brushes and combs in tub room. They confirmed that those items should not be in tub room and removed them. [s. 37. (1) (a)]

WN #34: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (1) Every licensee of a long-term care home shall ensure that a Residents' Council is established in the home. 2007, c. 8, s. 56 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Residents' Council is established in the home.

An interview was conducted with S #100 and they reported that the home didn't have a Resident's Council. They further reported that the home's admission package contains information about the Residents' Council.

Upon review of the Admission package, p. 15 states, "The Residents' Council is an elected body of residents (family members may represent a resident at the meetings of the Resident Council). This council represents all residents in the home. It is a vehicle through which residents can participate in the planning efforts of the home, thereby contributing to their home environment and well-being of themselves and their peers".

An interview was conducted with S #119 and S #101, and they reported that residents do not have input into the satisfaction surveys [s. 56. (1)]

WN #35: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

During the inspection, the bulletin board in the corridor outside the dining room was reviewed by the inspector and the site Administrator S #100 for the required information. The previous inspection reports and orders were secured to the top corner of the board, out of reach of residents in wheelchairs, and not in a conspicuous and accessible location. [s. 79. (1)]

WN #36: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

During a review of the medication cart, a bottle of vitamins was observed. According to S #105 the vitamins were brought in by the SDM of a resident and that the pharmacy service provider doesn't supply it. [s. 122. (1)]

WN #37: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee has failed to ensure that an emergency drug supply for the home shall ensure, (a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept.

During the inspection, the emergency drug storage area in the medication room was reviewed for its contents. It was reported by S #105 that there is no actual emergency drug box, but instead there is was cupboard drawer in which some medications were stored. In addition, they reported that if medications are needed after hours, they would call the hospital and obtain them or would wait until the pharmacy could provide them. The cupboard drawer was observed to have pharmacy labeled antibiotics, three different types, a medication spray and a bottle with six tablets of diurectic. In addition, there were two boxes of medication labeled by the pharmacy service provider, with the name of a deceased resident and according S #105 they were being kept in case they were needed for another resident in the home. [s. 123. (a)]

WN #38: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; O. Reg. 79/10, s. 212 (4).
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d); O. Reg. 79/10, s. 212 (4).
(c) has demonstrated leadership and communications skills; and O. Reg. 79/10, s. 212 (4).
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that that everyone hired as an Administrator after the coming into force of this section, (d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time.

During an interview, Inspector #577 spoke with site Administrator S #100, who reported that they have not completed and are not enrolled in a program in long-term care administration or management. They reported that they are a Registered Practical Nurse, with prior working experience as a Manager for two years in the health sector. They further reported that they have been employed as site Administrator since November 25, 2014. [s. 212. (4)]

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

Issued on this 29th day of May, 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) :	LAUREN TENHUNEN (196), DEBBIE WARPULA (577), JENNIFER KOSS (616)
Inspection No. / No de l'inspection :	2015_246196_0007
Log No. / Registre no:	S-000794-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 25, 2015
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	NORTHWOOD LODGE 51 Highway 105, P.O. Box 420, RED LAKE, ON, P0V-2M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kandice Henry

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 shall prepare, submit and implement a plan for achieving compliance with s.6(1)(c) of the LTCHA. The plan is to include:

1) The steps for ensuring that the care plans for all residents, including residents #025, #012 and #004 provide clear direction for staff and others who provide care.

2) Education for all staff who contribute to care planning. This would include:
- the purpose for; and importance of the resident's care plan
- the requirements for care planning as stated in the LTCHA
- the home's process for creating and maintaining care plans for all residents

This compliance plan is due to be submitted by Friday June 12, 2015, to LTCH Nursing Inspector #196
via email.

Grounds / Motifs :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

During the inspection, resident #004 was observed to be seated in a specialized chair with a restraint in place attached at the back of the chair. An interview was

conducted with S #110 and it was reported that resident #004 couldn't "really" walk, therefore the restraint was used to keep them safe.
The current care plan was reviewed for information regarding the use of a restraint and a specialized chair. Under the problem focus of "ADL assistance", related to restraint use, the intervention of "Gerri-chair with Traytable" was listed. Under the problem focus of "physical restraints PASD", the plan noted the "use of a trunk restraint and use of a chair that prevents rising" but did not specify the type of trunk restraint to be used or when the restraint was to be used for resident #004.
The "Activation Care plan", included the intervention of "Escort (resident #004) to activity by walking (them) to area right from point A to B as (they) will veer off and not attend" yet as reported by S #110 the resident couldn't walk.
In addition, the "Northwood Lodge Hourly Monitoring Record" for resident #004, for a particular month was reviewed for information. The type of restraint in use was not identified on this document, yet staff were recording the application, monitoring and resident response on this form.

The written plan of care for resident #004 did not set out, clear directions to staff and others who provide direct care to the resident.

(196)

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

An interview was conducted with S #110, and the continence status and care needs of resident #004 were reported.

The current care plan under the problem focus of "Continence Care" identified the frequency of incontinence and included interventions for toileting but did not specify a schedule or times that this task is to be performed. Under the problem focus of "Risk of Injury from falls" the interventions included "establish a bowel/bladder routine" but the plan did not identify a routine. Under the focus of "ADL Functional Rehabilitation" the interventions included "Encourage (resident

#004) to perform tasks independently, e.g. get out of chair and walk to bathroom" and then it reads "requires two or more persons at this time but if mechanical lift needed will be ceiling lift".

The written plan of care did not set out clear directions to staff and others who provide direct care to the resident, specifically, the plan did not identify when to toilet resident #004, the plan did not include a bowel/bladder routine and it noted that resident #004 could walk to the bathroom when elsewhere in the plan it noted that they couldn't walk.

(196)

3. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

Resident #001 was observed throughout the course of inspection to have a restraint in place while seated in a specialized chair. The monitoring record for a one week period, was reviewed and did not specify which type of restraint or PASD was in use but did include the initials of staff that had applied/repositioned/monitored the use of a restraint for resident #001. The current care plan was reviewed and under the under the focus of "Physical Restraint - PASD", the restraint observed in use was not included in the interventions and instead it listed the use of a seat belt, geri-chair, tray table and tilt recline chair. The use of a the restraint used by the resident was ordered by the physician in the winter 2015.

The written plan of care for resident #001 identified different types of restraints but did not identify the restraint used by the resident, as was observed in place during the course of inspection. As a result, the written plan of care did not provide clear directions to staff and others who provide direct care to the resident.
(196)

4. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

During the inspection, resident #025 was observed and a specific safety intervention was in use. The progress notes indicated this strategy was in use but it was not included in resident #025's plan of care.

On a another day, resident #025 was observed walking in the corridor with staff and the safety intervention was not in use. Later that same day, S #100 reported that the intervention that had been in use for resident safety was removed in order to evaluate the resident. When asked if there were additional strategies to monitor resident #025 without this specific intervention, S #100 stated no and that the Business Office staff would be monitoring the doors. It was then confirmed by S #100 that information pertaining to the use of this specific safety intervention should be included in resident #025's care plan.

The progress notes for resident #025 were reviewed and there was no documentation pertaining to the removal of the safety intervention and no documentation regarding family notification of its removal.
S #111 was questioned regarding this safety intervention and they were unsure if it was still in use and there was no communication shared at shift report about it not being in use. In addition, S #111 reported that staff responds when resident #025 attempts to exit and the door alarm sounds, they would go to the door and redirect resident. They also reported there were no specific techniques they were aware of, but it may take more than one staff person to redirect resident #025. The support of additional or alternate staff required to redirect resident was not included in resident #025's plan.

The written plan of care for resident #025 did not set out clear directions to staff and others who provide direct care to the resident, specifically, there was no reference to the use of this specific safety intervention nor strategies to respond to responsive behaviours in the plan.

(616)

5. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

During the inspection, Inspector #577 observed two full bed rails elevated for resident #012. The care plan was reviewed and included the type of transfer and assistance the resident required but did not identify the use of bed rails. The bed rail assessment form indicated the use of toilet and window side assist rail. It was confirmed by S #119, that the use of bed rails should be included in the resident's care plan.

The written plan of care for resident #012 did not set out clear directions to staff and others who provide direct care to the resident, specifically, did not include the intervention of bed rail use.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 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. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Order / Ordre :

The licensee shall ensure that resident #014, and all other residents, are provided with food and fluids that are safe, specifically residents who receive a textured diet.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

On a particular day in April 2015, Inspector #577 spoke with resident #014's spouse, and they had reported that minced food for the residents aren't consistently served in a minced texture. In addition, they reported that they had reported this on two occasions to the home's Administrator. An example was provided, they were feeding their family member a minced beef sandwich and found a large piece of formed beef, approximate 3 inches in length. On another day in April 2015, Inspector #577 was approached by this same family member, and was shown a formed piece of chicken, approximately 3 inches in length and 2 inches in diameter. They reported this piece of formed meat was found in resident #014's pureed meal four days ago, on the week-end. Inspector reviewed resident #014's plan of care, and it indicated that the resident is on a special diet that includes minced textures.
During the inspection, on a particular day, the provision of meals was observed during the lunch service and three plates of minced diets did not contain food with a consistent minced texture. A formed piece of fried beef, approximately 5cm in length and diameter was observed on one plate, and two other plates had green beans that were still formed and not in a minced texture. Inspector confirmed this consistency with dietary aide S #117, and S #113, and the

registered staff S #103 was informed.

Inspector #577 met with S #128 and discussed concerns with minced diets not being consistently served in that texture. They reported a hand blender is used to mince food and further reported they were unaware of concerns about diet textures.

The licensee did not ensure that residents were provided with food and fluids that are safe, adequate in quantity, nutritious and varied, specifically for those residents assessed as requiring a minced texture diet.

Previous non-compliance was identified from the RQI conducted February 18, 2014. Inspection report 2014_211106_0006
LTCHA 2007,c.8,s.11.(2) WN/VPC

(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that resident #026, #027 and #001, and all residents in the home, are provided with a between-meal beverage in the morning and afternoon and a snack in the afternoon and evening.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

The snack pass was observed in the afternoon of a particular day during the inspection, and S #110 was seen to go past resident #001's room and not enter to offer the resident a snack or beverage. An interview was then conducted with S #110 and they reported that resident #001 was to receive a nutritional supplement at afternoon snack time but it was not provided as the resident was too tired and it would just be given at HS if they were sleeping in the afternoon.

On a particular day, during the inspection, resident #001 was not offered a between-meal beverage in the afternoon.

(196)

2. The licensee failed to ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the

evening after dinner.

An interview was conducted with S #112 and S #102 and they reported that beverages aren't given on day shift, and further reported they are given at 1500hrs and later in evening.

The licensee failed to provide between-meal beverages in the morning and afternoon.

(577)

3. The licensee has failed to ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning.

The meal and snacks times as posted in the servery read "10 a.m. juice". The Resident Admission Handbook was reviewed and also indicated "Beverage 10:00 a.m.".

On a particular day during the inspection, the provision of a between meal beverage in the morning was not observed to take place. An interview was conducted with S #115 confirmed that no beverages were offered between breakfast and lunch on any days. They also reported that if requested, staff will provide a beverage to a resident and the nurses give water with pills. An interview was then conducted with S #113 and they reported that the kitchen staff gives the morning snack and beverage, nursing gives extra fluids in the morning, separate from the medication pass. S #113 clarified they "thought" the kitchen staff only gives morning snack to residents in the front television room.

The "Food and Nourishment Daily Record" for residents #026 and #027 was reviewed. The mid-morning nourishment "fluids taken" for resident #026 was noted on three of 30 days and resident #027's mid-morning nourishment "fluids taken" was noted one of 30 days.

(616)

4. The licensee has failed to ensure that each resident is offered a minimum of,

(c) a snack in the afternoon and evening.

The snack pass was observed in the afternoon of a particular day, during the inspection, and S #110 was seen to go past resident #001's room and not enter to offer the resident a snack or beverage. An interview was then conducted with S #110 and they reported that resident #001 was to receive a nutritional supplement at afternoon snack time but it was not provided as the resident was too tired and it would just be given at HS if they were sleeping in the afternoon.

The health care records for resident #001 were reviewed and the nutritional risk assessment identified them as being a high nutritional risk with a history of 9.5% loss of body weight over a specific time period. In addition, S #116 reported in an interview, that the nutritional assessment noted that this resident's energy requirements were not being met and upon review by the RD, it was determined that the nutritional supplement had not been given despite being ordered to start twice daily in December 2014.

Resident #001 was not offered a snack in the afternoon, specifically a nutritional supplement, despite being a high nutritional risk.

Previous non-compliance was identified from the RQI conducted February 18, 2014. Inspection report 2014_211106_0006
WN/VPC O.Reg.79/10,s.71.(3)(c)

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance under s.19(1) of the LTCHA. The plan is to include:

1) Interventions to be implemented to monitor resident #001 that will ensure that residents in the home are protected from sexual abuse.

2) Strategies to manage resident #001's behaviours, considering psychological, pharmaceutical, behavioural and physical interventions. Resident responses to be documented.

3) Interventions to be implemented to ensure that staff members do not neglect residents in their care.

4) Education to be provided that will ensure that staff members are knowledgeable of the licensee's policy of zero tolerance of abuse and neglect of residents, duty to report and abuse decision trees.

5) A process to ensure that all matters as detailed in LTCHA 2007,c.8.s.24.(1), 195 (2) are immediately reported to the Director and investigated by the licensee.

This compliance plan is to be submitted by Friday June 12, 2015, to LTCH Nursing Inspector #196 via email.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are not neglected by the licensee or staff.

A Critical Incident System report was submitted to the Director for an incident of alleged neglect of resident #015 by two staff members in the home. The home's investigation determined that S #121 and S #123, had neglected to check the safety and hygiene of resident #015 on a particular shift, which led to risk of harm.

During the inspection, the employee file for S #121 was reviewed and it identified a similar incident of neglect towards resident #015 which had been alleged to have occurred earlier that same month, by this same staff member. An interview was conducted with S #120 and they reported that the incident which had occurred earlier that same month, had not been reported to the management of the home, District Manager/CEO and Human Resources, until approximately a week and a half after its occurrence. In addition, it was determined that the incident alleged to have occurred earlier in the month, had not been reported to the Director.

The licensee had been made aware of alleged neglect of resident #015 by S #121, yet they continued in their PSW position and a second incident of neglect had occurred later that same month, towards this same resident.

S #121 had been alleged to neglect resident #015 on a particular day, and it was not reported to the management of the home until one and a half weeks later. A second incident of neglect towards this same resident, by this same staff, occurred later that same month.

(196)

2. The licensee has failed to ensure that residents are protected from abuse by anyone.

The O.Reg.79/10,s. 2.(1)(b) identifies "sexual abuse" to be "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

The health care records for resident #001 were reviewed for information

regarding responsive behaviours. The progress notes, over an approximate two month period, identified several incidents of sexual abuse by resident #001 towards other residents in the home.

An interview was conducted with S #100 and they reported that resident #001 did have sexual behaviours in the past, and stated "nothing too serious". Direct care staff members that were interviewed also reported a history of sexual behaviours towards female residents in the home and provided examples of incidents in which residents were sexually abused.

An interview was conducted with the District Manager/CEO S #101 and they reported that they were aware of some of the responsive behaviours of resident #001, but that the staff at the home had wanted the resident discharged from the home rather than deal with the behaviours. In addition, after discussion with S #101, it was determined that the incidents of sexual abuse towards female residents by resident #001 was not investigated and was not reported to the MOHLTC Director.

The care plan that was in effect at that time of these incidents for resident #001 was reviewed, and did not include strategies or interventions aimed at preventing incidents of sexual behaviours towards other residents in the home.

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

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 : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall ensure that any person who has reasonable grounds to suspect abuse or neglect may have occurred, will immediately report this information to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that any 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: 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.

During the inspection, the employee file for S #121 was reviewed and it included information that had been sent to S #101 and Human Resources. The information outlined an incident in which S #121 was alleged to have neglected resident #015, specifically, did not provide personal care, approximately one and a half weeks earlier.

An interview was conducted with S #120 and they reported that the incident which had occurred had not been reported to the Director immediately, nor was the incident reported to the Director at a later time. The licensee conducted an

investigation into the reported incident as well as the incident that had occurred later that same month and subsequently terminated S #121 after determining that neglect had occurred on two separate occasions.

A separate incident of neglect towards a resident had occurred earlier in that same month, and it was not reported to Director.
(196)

2. The licensee has failed to ensure that any 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: 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.

A Critical Incident System report was submitted to the Director outlining an incident of alleged neglect of resident #015 that had occurred on a particular day. It was not reported to the Director immediately as required, and instead reported after the licensee's investigation had been concluded.

(196)

3. The licensee failed to ensure that any 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: 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.

The O.Reg.79/10,s. 2.(1)(b) defines "sexual abuse" as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

The health care records for resident #001 were reviewed for information regarding responsive behaviours. The progress notes, over a two month period included several incidents of sexual behaviours towards other residents in the home.

An interview was conducted with the S #100 and they reported that resident #001 did have sexual behaviours in the past, and stated "nothing too serious". Direct care staff members that were interviewed also reported a history of sexual

behaviours towards female residents in the home and provided examples of incidents in which residents were sexually abused.

An interview was conducted with S #101 and it was confirmed that the Director was not notified of any of the incidents of sexual abuse towards female residents by resident #001 as they were resident to resident incidents.

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

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 : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
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.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with O.Reg.79/10,s.110.(2)1 and s.110(2)6. The plan is to include:

1) Education, to be implemented for staff members, that will ensure that only physical restraint devices that have been ordered, are used on residents in the home.

2) Education, to be provided to registered staff that will ensure they are knowledgeable of the LTCHA requirements relating to the restraining of residents and the home's expectations for documentation.

3) A plan to ensure that all restrained residents have their condition reassessed and the effectiveness of the restraining evaluated at least every eight hours, and any other time when necessary.

This compliance plan is due to be submitted by Friday June 12, 2015, to LTCH Nursing Inspector #196 Lauren Tenhunen via email.

Grounds / Motifs :

1. The licensee has failed to 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.

During the inspection, resident #004 was observed sitting in a specific type of chair with a restraint in place and attached at the back of the chair. According to S #110, resident #004 "can't really walk", so the restraint was used to keep them safe.

The health care records for resident #004 were reviewed. The "Personal Assistance Services Device Consent Form" was signed on admission by the SDM and witnessed by S #105 and identified the use of a seat belt, table tray, geriatric chair, tilt-recline chair, for all shifts and contained pre-signed signatures of the Medical Director and the Administrator. According to S #105, these forms are signed on admission to the home for all residents.

An interview was conducted with S #105 and the "Personal Assistance Services Device Consent Form" for use of restraints was reviewed and the type of restraint that was observed in use was not included for use on resident #004. S

#104 also confirmed that an physician's order for the use of this specific type of restraint and consent from the SDM had not been obtained.

The current care plan with focus problem of "Physical Restraints-PASD" identified the use of a "trunk restraint" and "use of a chair that prevents rising".

Resident #004 was restrained by a physical device, specifically, a specific type of restraint, and the health care records did not contain a physician's order for this type of device.

(196)

2. The licensee has failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Resident #001 was observed sitting in a wheelchair on a particular day during the inspection, with a restraint in place and attached at the back of the chair.

The "Northwood Lodge Hourly Monitoring Record" for a one month period was reviewed and it included a space for the registered staff to initial every eight hours to acknowledge that the resident's condition was reassessed and the effectiveness of the restraining was evaluated. On eighteen shifts out of a seven day period, the registered staff had not initialed.

An interview was conducted with registered staff S #102, and it was reported that the registered staff do not initial every eight hours to acknowledge the reassessment of restraint use on a resident.

An interview was conducted with registered staff S #104 and they reported that they don't reassess the need for a restraint every eight hours, they will look at the resident, but do not reassess the continued need for the restraint or its effectiveness. In addition, it was reported that the PSW's are to check the

restraint every hour, check for tightening, make sure resident's haven't taken them off, they are working properly, and that there is no injury to the resident.

Resident #001 was restrained by a physical device, and the resident's condition and the effectiveness of the restraining was not assessed by the registered nursing staff, at least every eight hours.

Previous non-compliance was identified from the RQI conducted February 18, 2014.
Inspection report 2014_211106_0006.
O.Reg.79/10,s.110.(2)6 WN/VPC

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

Order # / Ordre no : 007

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

Linked to Existing Order / Lien vers ordre existant: 2014_211106_0006, CO #001;

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 shall prepare, submit and implement a plan for achieving compliance under s.6.(7) of the LTCHA. The plan is to include:

1) A method that will ensure that all residents receive the care as specified in their care plan.

2) Identify how the interdisciplinary staff members will be informed of changes in resident care needs and ensures communication between all staff providing care.

This compliance plan is due to be submitted by Friday June 12, 2015, to LTCH Nursing Inspector #196 via email.

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.

Resident #001 had altered skin integrity as documented in the wound consultation note done in January, 2015 by the RN EC.

On a particular day during the inspection, resident #001 was observed over a two and a half hour period seated in a specialized chair and the chair was not repositioned.

The current care plan, under the focus of altered skin integrity included the

intervention of "HCA tilts (resident #001) chair to new position hourly".

The care set out in the plan of care was not provided to resident #001, specifically, the resident was not repositioned in their specialized chair hourly.

(196)

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

The health care records for resident #001 were reviewed and the Physician's order sheet included an order for a nutritional supplement to be given. The MAR sheet for resident #001, had an area to record the administration of the nutritional supplement OD (daily) but it was not documented as being provided on two specific days and a "9" was recorded on three other days. According to the legend on the MAR sheet, "9" represents "hold".

Resident #001 was ordered by the physician to receive a nutritional supplement one scoop daily and they did not receive it on five specific days. There was no documentation as to the reason it was not provided.

An interview was conducted with the RD S #116 regarding resident #001's nutritional plan of care. It was reported that at the last resident care conference, it was identified that the resident had been getting a specific diet texture with thickened fluids and they were to receive a different texture when alert and a specific diet texture when very lethargic. In addition, S #116 was unclear when the thickened fluids had started and reported that resident #001 shouldn't have been on them.

The nutritional assessment documented, most recently, online by the RD, identified high nutritional risk, continued weight loss, noted that intakes had remained the same and the cause for weight loss was unknown. The assessment also noted "(they) had been getting only a specific diet texture for months (diet order for a specific diet texture when lethargic only), there is a nutritional gap between the two types of textured diets and with increased energy requirements for healing, (they are) likely not getting adequate nutrients or energy" and that they had been on thickened fluids for a period greater than 6 months for an unknown reason.

The care set out in the plan of care, for resident #001, was not provided as specified in the plan, specifically, the incorrect diet texture and thickened fluids was given and not the diet that was originally ordered.

(196)

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

A copy of the dietary reference sheet posted in the servery was reviewed as the supper meal was observed.

Resident #018 was observed to eat cut up pieces of pork chop, approximately 1cm X 1cm, yet the dietary reference sheet identified a specific texture other than cut as the food texture that was to be provided. The Dietary Aide S #117 was questioned and confirmed that a cut up pork chop had been provided to this resident.

The current care plan for resident #018 was reviewed and under the problem of "nutritional care" there was an intervention of a specific diet texture.

The care set out in the plan of care, for resident #018 was not provided to the resident as specified in the plan, specifically, the incorrect texture of food was given during the dinner service on a particular day during the inspection.

(196)

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

On a particular day, during the inspection, the evening supper meal was observed. Resident #017 was observed to be assisted with with the meal by S #109 and they reported that the resident had juice and tea to drink. An interview was conducted with Dietary Aide S #117 and they reported that the ordered supplement was not provided to resident #017 tonight and a specific type of juice was not provided.

The current care plan, as found at the nursing desk, was reviewed and included the problem of "nutritional care" and the interventions listed a specific type of juice to be offered and the supplement to be provided at meals.

The dietary reference sheet as was posted in the servery, was copied and reviewed for information regarding resident dietary requirements and included the same information as in resident #017's care plan.

The care set out in the plan of care was not provided to resident #017 as specified in the plan, specifically the resident was not offered a specific type of juice and the supplement was not added to the supper meal.

(196)

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

The health care records for resident #001 were reviewed and the nutritional risk assessment identified this resident to be high risk with a history of 9.5% loss of body weight over a specific period of time. The current care plan, under the focus of nutritional care, included the intervention of "boost pudding at PM and HS snack". The "food and nourishment daily record" for an approximate one month period in 2015 did not identify whether a nutritional supplement, for either the PM mid-afternoon nourishment nor the HS evening nourishment, was provided.

An interview was conducted with the RD and it was reported that in December 2014 the nutritional supplement was added to the resident's diet twice daily, at PM and HS snack. When the nutritional assessment was done two months later, it was noted that energy requirements were not being met and upon review by the RD it was determined that the nutritional supplement was not being given to the resident.

On a particular day, during the inspection, the PM snack pass was observed and S #110 was observed to go past resident #001's room and not enter to offer the resident a snack or beverage. An interview was conducted with S #110 and it was reported that resident #001 was to receive a nutritional supplement at

afternoon snack time but it was not given as the resident was too tired and it would just be given at HS if they were sleeping in the afternoon.

Resident #001 did not receive the ordered nutritional supplement on this day during the inspection. In addition, it was confirmed by the RD that this nutritional supplement had not been provided twice daily to resident #001 from December 10, 2014, to February 3, 2015.

An interview was conducted with the RD and it was reported that a different nutritional supplement was increased from TID (three times daily) to QID (four times daily) on a particular day in April 2015. The MAR (medication administration record) was reviewed for the month of April and the increase had not been initiated until eight days after it was ordered.

The care set out in resident #001's plan of care was not provided to the resident as specified in the plan, specifically, the increase of a nutritional supplement was not initiated until eight days after being ordered by the RD, a different nutritional supplement was not given on a particular day as observed during the inspection and the nutritional supplement was not provided by the staff from December 10, 2014, to February 3, 2015

(196)

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.

On a particular day during the inspection, Inspector #577 observed resident #013 lying in their bed after lunch, and a strong smell of urine was noted.

The care plan for resident #013 was reviewed and identified the continence status of the resident and included the intervention of a toileting routine and repositioning of the resident in their chair hourly. The care plan did not indicate a specific toileting schedule.

On another day, during the inspection, resident #013 was observed at 1100hrs, 1200hrs, 1300hrs and 1400hrs, to be seated up in their wheelchair in the same position, and not re-positioned by staff or toileted. An interview was conducted with S #112 on this same day at 1415hrs, who confirmed that resident #013 had

not been toileted today, since getting up in tilt chair at 0700hrs.

On another day, during the inspection, resident #013 was observed at 0915hrs, 1100hrs, and 1200hrs, to be seated up in their wheelchair in the same position, and not re-positioned by staff or toileted. An interview was conducted with S #108 later that day, and they reported that resident #013 was repositioned, continence care was provided and they were put back to bed at 1330hrs. An interview was then conducted with S #100 and inquired about their expectations concerning repositioning and toileting of residents that are in wheelchairs and cannot reposition themselves. They reported that their expectation is that residents will be repositioned and toileted after breakfast 1000hrs, after lunch and also at 1400hrs.

The care set out in the plan of care for resident #013 was not provided to the resident as specified in the plan, specifically, continence care was not provided and the resident was not repositioned.

Previous non-compliance was identified from the RQI conducted February 18, 2014.
Inspection report 2014_211106_0006.
Compliance Order LTCHA 2007,c.8,s.6.(7).

(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

Order # / Ordre no : 008

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

Linked to Existing Order / Lien vers ordre existant: 2014_211106_0006, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with O.Reg.79/10,s.73.(1)5. The plan is to include:

1) That ensures that the home has a dining and snack service that includes a process to ensure that food service workers and other staff assisting residents are aware resident #017, #007, #018 's diets, special needs of resident #015 and preferences of resident #028, and all other residents to which this may apply.

This compliance plan is due to be submitted by Friday June 12, 2015, to LTCH Nursing Inspector #196 via email.

Grounds / Motifs :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

On a particular day during the inspection, the dietary reference sheet as was posted in the servery, was copied and reviewed for information regarding resident dietary requirements.

On this same day, resident #017 was observed to be assisted with their supper meal. S #109 was interviewed and they reported that the resident had thickened juice and tea to drink. Dietary Aide S #117 was asked if a supplement was put into resident #017's food and they reported that it was not given, nor was the specified type of juice offered, despite the dietary reference sheet had it listed.

Resident #028 was observed with a glass of juice and the Dietary Aide S #017 reported that they were not provided with the type of juice as listed on the dietary reference sheet.

At this same meal, S #130 was observed to assist resident #007 with a bowl of apricots that had been cut into approximately 1cm X 1cm pieces, yet the dietary reference sheet identified a diet texture different from cut foods.

Resident #018 was observed to eat cut up pieces of pork chop, in approximately 1cm X 1cm size, yet the dietary reference sheet identified a diet texture different than cut as the food texture that was to be provided. The Dietary Aide S #117

was questioned and confirmed that a cut up pork chop had been provided to this resident.

Resident #015 was observed with silverware on the table in front of them, and included a knife, fork and spoon. The dietary reference list read "no knives, plastic utensils". S #110 was questioned why the resident could not have silverware and they reported that it was because they used to walk away with these items, but they don't walk anymore.

Despite having a dietary reference sheet that was readily available to food service workers and other staff assisting residents, several residents were not provided with the correct diet textures, their preferences and the ordered recommendations on that particular day during the inspection.

(196)

2. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

On a particular day, during the inspection, S #115 provided a diet census list from the nourishment cart reportedly used by staff during afternoon snack pass. The census list indicated resident names, diet type, texture, "Other" (supplements, special preferences, allergies, dislikes), choking risk, tea/coffee. Two residents were identified, #026 and #027, as being on ordered fluid restrictions.

A review of resident #026's Nutritional Care plan, and diet census, both noted fluid restrictions of a specific amount in 24 hours. A review of Food and Nourishment Daily Record indicated that on 13 of 28 days, resident #026's documented fluid intake exceeded this amount in 24 hours.

A Review of resident #027's Nutritional Care plan, and diet census, both noted fluid restrictions of a specific amount in 24 hours. A review of Food and Nourishment Daily Record indicated that on 16 of 28 days, resident #027's documented fluid intake exceeded this amount in 24 hours.

There was no indication of ordered fluid restriction in the "comments about special needs" on the Food and Nourishment Daily Record for either resident #026 and #027.

As S #113 was starting the afternoon nourishment pass at in the afternoon on a particular day, during the inspection, they were asked if there were any residents on fluid restrictions. S #113 reported there was no one on fluid restriction currently and they (staff) would receive that information during shift report. In addition, it was reported if (residents) are on fluid restriction for a long time, it is on the memo board in the report room. The memo board in the report room had no reference to fluid restrictions ordered for residents #026 and #027.

Inspector #616 observed S #107 and S #113 as they continued with the nourishment pass. The inspector brought to their attention the fluid restrictions for both residents #026 and #027. S #107 stated they were not sure if both residents were still on restrictions, further adding they thought the residents might have "been taken off", and advised the inspector to ask the nurse. S #113 later clarified to the inspector they just noticed the clipboard on the nourishment cart that outlined diets but had not seen the clipboard before. At this time, S #107 confirmed the clipboard has been on the nourishment cart for the last few months however it was inconsistent depending on which kitchen staff was working. However, S #107 reported the diet census had been with the nourishment cart more consistently over the last few months. S #107 and #113 were unable to provide clear knowledge of residents on fluid restriction.

On another day, an additional form was observed at the servery counter "Dietary needs of all resident must be checked at time of meal". S #115 reported that it is the PSW's responsibility to sign off each meal. Review of this form, for one specific day, noted Breakfast and Lunch each checked for all residents whereas the supper column was unchecked for all residents. On another day, the noted columns for each Breakfast, Lunch and Supper were unchecked for all residents. On the date of review, each column for Breakfast and Lunch were unchecked for all residents at 1415hrs.

Previous non-compliance was identified from the RQI conducted February 18, 2014.
Inspection report 2014_211106_0006

Compliance Order O.Reg.79/10,s.73.(1)5.

Inspection report 2013_211106_0042 December 3, 2013
WN/VPC O.Reg.79/10,s.73.(1). (616)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

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 : 009

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 71. (1) Every licensee of a long-term care home shall ensure that the long-term care home has a Director of Nursing and Personal Care. 2007, c. 8, s. 71. (1).

Order / Ordre :

The licensee shall ensure that the the long-term care home has a Director of Nursing and Personal Care.

Grounds / Motifs :

1. The licensee failed to ensure that the long-term care home has a Director of Nursing and Personal Care.

On April 22, 2015, a photocopy of the newspaper advertisement for the local newspaper, was provided to the Inspector, to demonstrate the licensee's active recruitment for a Director of Nursing for Northwood Lodge.

The long-term care home has not had a Director of Nursing (DON), working on site at the home since November 5, 2014.
(196)

2. The licensee has failed to ensure that the long-term care home has a Director of Nursing and Personal Care.

During the inspection, Inspector #577 and #196 met with S #100 who reported that the home has not employed a Director of Nursing since November 6, 2014. The previous Director of Nursing (DON), S #122, left the position in September 2014 and then S #119 took on the role of DON through to November 5, 2014. (577)

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 : Jun 26, 2015

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 : 010

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 20.(1) of the LTCHA. The plan is to include:

1) Establish a plan to provide education to all staff regarding the licensee's written policy on zero tolerance of abuse or neglect of residents.

2) The education is to include mandatory reporting and the duty to report, the procedure to follow for reporting incidents of abuse or neglect of residents, and the use of the decision trees to assist in determining incidents that must be reported to the Director.

3) Contact information for the Director and after hours pager number is to be readily available for those staff in charge at the home in the event of an reportable incident.

This compliance plan is due to be submitted by Friday June 12, 2015, to LTCH Nursing Inspector #196 via email.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

On a particular day in 2014, management was made aware of an incident in which S #121 was alleged to have neglected resident #015, specifically, did not provide personal care, on an earlier day in 2014. The licensee's written policy to

promote zero tolerance of abuse and neglect of residents states that "neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O.Reg.79/10,s.5.".

The licensee's written policy reads, under "Mandatory Reporting under the LTCHA", that an immediate report to the MOHLTC Director where there is a reasonable suspicion that the following incidents occurred or may occur: 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. An interview was conducted with S #120 on and it was confirmed with the inspector that the incident of neglect, alleged to have occurred on that day in 2014 was never reported to the Director.

Secondly, a Critical Incident System report was submitted to the Director in 2014 for an incident of neglect from two staff members, S #121 and S #123 towards resident #015. An after hours pager call was not initiated by the licensee, nor was the Director notified immediately of the alleged incident of neglect and instead was notified after the licensee had conducted their investigation into the allegation of neglect.

An incident which had occurred in 2014, was never reported to the Director and the incident of neglect which had occurred on another day in 2014, was not reported immediately, but five days afterwards. The home did not comply with their own written policy to promote zero tolerance of abuse and neglect of residents.

(196)

2. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

The written policy ADM 450 titled "Zero Tolerance of Abuse/or Neglect" with revision date of 09/14, as provided by S #105, was reviewed for the required information. The written policy identified that "sexual abuse" means "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or

staff member" as is in O.Reg.79/10,s.2(1), and the policy included information on the the duty to make mandatory reports as in the LTCHA 2007,c.8,s.24.(1). However, despite having this written policy to promote zero tolerance of abuse and neglect, the incidents of sexual abuse that had occurred over an approximate two month time period, in 2014, by resident #001 towards residents in the home, had not been reported to the Director. In addition, the incidents were not investigated, nor was the SDM of resident #016 notified.

The home did not comply with their own written policy to promote zero tolerance of abuse and neglect of residents.

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

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 : 011

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours.

Inspector #616 reviewed the progress notes related to behaviours for resident #025 for a one month time period. and there was evidence of activity involving safety concerns.

The progress notes for (resident #025) included a note that the resident had attempted to drink hand sanitizer. Earlier this same day, Inspector #616 also observed resident #025 attempting to pour hand sanitizer into a half full glass of water at the nursing station and notified staff at that time.

Resident #025 care plan review indicated impaired communication related to problem understanding others . Intervention noted in Behaviour Problem/Mood State care plan is to "state clearly to resident #025 " This behaviour is not acceptable, please stop".

Inspector #616 spoke with S #102 regarding resident #025 behaviours and they reported that at a particular time of the day the resident has more difficulty and that the communication method for sharing a resident's behaviour triggers or interventions is by charting on the computer, or on the white board in report room. In addition, S #102 reported that resident #025 liked to be busy, with actions having purpose generally.

Inspector #616 spoke with S #114 regarding the activation care plan as finding none in resident #025 health record. S #114 reported maintains binder for all Activation Care plans separate from the residents health records and the admission assessment is currently incomplete.

Resident #025 had been demonstrating responsive behaviours, and the care plan did not include strategies aimed as responding to these behaviours.

(196)

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours, where possible.

The health care records for resident #001 were reviewed for information regarding responsive behaviours. The progress notes, over an approximate two month period, identified several incidents of sexual abuse by resident #001 towards other residents in the home.

An interview was conducted with S #100 and they reported that resident #001 did have sexual behaviours in the past, and stated "nothing too serious". Direct care staff members that were interviewed also reported a history of sexual behaviours towards female residents in the home and provided examples of incidents in which residents were sexually abused.

An interview was conducted with the District Manager/CEO S #101 and they reported that they were aware of some of the behaviours of resident #001, but that the staff at the home had wanted the resident discharged from the home rather than deal with the behaviours.

An interview was conducted with S #110 and they reported that resident #001 no longer had behaviours. S #108 reported that resident #001 used to have some sexual behaviours with other residents. The female residents, some of which remain unidentified, were not protected by the home from incidents of sexual abuse from resident #001.

The care plan, in effect at the time of these incidents, under the focus of "Behavior problem" and "sexually inappropriate" was reviewed. The plan did not include strategies aimed at minimizing these responsive behaviours, specifically sexually inappropriate behaviours.

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 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
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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 25th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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