Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 27, 2015	2015_323130_0007	H-002168-15	Resident Quality Inspection

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE NIAGARA FALLS ON L2E 6S5

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

GILLIAN TRACEY (130), KELLY HAYES (583), ROSEANNE WESTERN (508)

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 14, 15, 16, 17, 20, 21, 22, 23, 24, 27 and 28, 2015

**Please note the following inspections were conducted concurrently with this RQI:
Critical incidents: H-001405-14, H-000840-14, H-000446-14 and H-002048-15
Complaints: H-002245-15, H-000535-14 and H-002137-15.
Inspector Kelly Chuckry #611 conducted identified Critical Incident inspections during this RQI.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator and the RAI Coordinator Back-up, Registered Nurses (RNs), Registered Practical Nurses (RPNs), personal support workers (PSWs), Registered Dietitian (RD), Food Services Nutrition Manager (FSNM), dietary staff, Recreation Manager, Maintenance Supervisor, maintenance staff, President of Residents' Council, residents and families.

The following Inspection Protocols were used during this inspection:

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

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_201167_0010	130
O.Reg 79/10 s. 30. (2)	CO #001	2014_247508_0037	130

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

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

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the residents.

A) A review of resident #005's continence care plan goal identified resident #005 would be toileted by self safely and appropriately or with assistance by staff. The quarterly review assessment completed on a specified date in 2015 identified resident #005 required one person physical assistance with toileting. In an interview with PSWs it was confirmed that resident #005 required assistance from one staff member with toileting and that the direction in the continence care plan was unclear as it identified resident #005 was both able to toilet independently and required assistance from staff. (Inspector #583) [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the

resident and the resident's needs and preferences.

A) Resident #001 was frequently incontinent of urine and required assistance with toileting and required incontinence care. A review of the Minimum Data Set (MDS) for two identified months in 2014 and two identified months in 2015 indicated that the resident was frequently incontinent of urine. The resident's written plan of care identified the resident as being a potential for urinary incontinence; however, staff indicated that the resident was frequently incontinent.
It was confirmed by registered staff that the plan of care was not based on the assessment of the resident and the resident's needs and preferences. (Inspector #508)

B) In an interview with resident #007 it was shared they were not offered beverages in the morning, afternoon and evening and that there had been times the resident requested fluids between meals due to thirst and nothing was provided. A review of resident #007's plan of care identified they were on a fluid restriction and required extensive assistance with eating. The fluid plan created by the RD on a specified date in 2014 provided all of the alotted fluids with breakfast, lunch and dinner and did not offer fluids at the morning, afternoon or evening nourishment times. The plan of care did not contain interventions on how to control thirst for a fluid restriction. A review of the nutritional intake record over a number of days in 2015 showed resident #007 consumed an average of 493 milliliters of fluid daily. In an interview with the RD it was shared that the RD had not reviewed the fluid plan with resident #007 since it was created in 2014. It was confirmed resident #007's fluid preferences were not assessed during a specified time period in 2014 when quarterly nutrition assessments were completed. (Inspector #583) [s. 6. (2)]

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

A) On a specified date in 2015, resident #401 sustained a witnessed fall, which resulted in injury. The resident's plan of care identified the need for a safety device, to prevent self-ambulation. Staff interviewed and the critical incident notes confirmed at the time of the incident, the safety device was not fastened. Care was not provided in accordance with the resident's plan of care. (Inspector #130)

B) On a specified date in 2015 resident #200 was observed to be left unattended on the toilet with the bathroom and bedroom door fully opened. In an interview with the front line nursing staff it was shared the resident was not supposed to be left unattended during

toileting. A review of the care plan identified resident #200 was assessed to be totally dependent for toileting and required two person physical assistance for the task. In an interview with the registered staff it was confirmed that the care set out in the plan of care was not provided as specified in the plan.(Inspector #583)

C) On a specified date in 2015, it was observed that one PSW entered resident #013's room pushing the resident in their chair. A few minutes later, it was observed that the resident was lying in their bed and there was only one PSW in the resident's room. Resident #013 had indicated to Inspector #130 and Inspector #508 that one staff person transferred them using a mechanical lift from the resident's chair to their bed, independently.

A review of the resident's written plan of care indicated that the resident required total assistance of two staff using a mechanical lift for all transfers.

It was confirmed during an interview with registered staff that care was not provided to resident #013 as specified in the plan of care. (Inspector #508)

D) On a specified date in 2015, resident #300 was observed seated in their wheelchair with a loose fitting safety device applied. The resident was unable to unfasten the device on command. The DOC assessed the device at the request of Inspector #130 and confirmed the device was not properly applied. The DOC spoke with the registered staff about the device and advised the Inspector that the resident was not authorized to have a safety device applied. The plan of care did not identify the need for a safety device. Care was not provided as specified in the plan of care. (Inspector #130)

E) A review of the plan of care for resident #007 identified they were at high nutrition risk, had variable oral intake and required an individualized diet plan. Resident #007 was ordered a specialized diet by the RD. A review of the written care plan interventions created by the RD, identified the RD would liaise with the specialized RD as required. The RD assessments completed from 2014 to 2015 did not identify the RD liaised with the specialized RD. In an interview with the RD it was confirmed the RD had not communicated with the specialized RD in regards to resident #007. It was shared that information from the specialized RD including resident #007's blood work, fluid balance, dry weights and education provided by the specialized RD could have been valuable when completing the nutrition assessments. It was identified this information would help to assess whether resident #007 nutritional requirements were being met with their individualized diet plan. (Inspector #583) [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or when care set out in the plan was no longer necessary.

A) A review of resident #005's continence quarterly review assessment completed on a specified date in 2015 identified resident #005 was frequently incontinent and required a pull up brief during the day and a medium brief at night. A review of the urinary incontinence care plan, last revised on a specified date in 2014 identified resident #005 had occasional incontinence and the intervention directed staff to provide resident #005 with liners. In an interview with the PSWs and RAI Coordinator it was confirmed that resident #005 was frequently incontinent and required a pull up brief and that the continence care plan was not updated when the resident's care needs changed. (Inspector #583)

B) The Minimum Data Set (MDS) RAI Annual Review Assessment completed for resident #002 on a specified date in 2015, indicated the resident had an area of skin impairment; however, the written plan of care indicated the resident had more than one area of skin impairment. The RAI Coordinator verified the resident had one area of skin impairment and confirmed that the written plan of care had not been updated when the resident's condition had changed. (Inspector #130)

C) The written plan of care for resident #402, developed in 2014, indicated the resident had potential for complications related to a specific diagnosis. An intervention identified in the written plan included the need for a specific treatment. The written goal identified that the complications would resolve over the next quarter. During the same time period the written plan also indicated the resident had ulceration or interference with structural integrity of layers of skin. The written goal identified that a specific area of skin impairment would show a reduction in size over the next quarter. The resident was observed during continence care on a specified date in 2015 and did not have the specific treatment in place as specified in the plan. The registered staff on the unit confirmed the specific treatment was discontinued in 2014. The MDS quarterly assessment completed in 2015 confirmed that the area of impaired skin was intact. On an identified date in 2015, the resident was observed to have a newly identified area of impaired skin integrity to a specific area. The PSW confirmed the area was new. Registered staff assessed the resident on a specified date in 2015 and it was confirmed by the RAI Coordinator that the area was impaired. The plan of care was not updated when the resident's original area of skin impairment had healed, when the specific

treatment was discontinued, nor when the new skin impairment was identified. This information was confirmed by registered staff. (Inspector #130) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the residents, to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences and to ensure that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) The home's policy CD-05-18-1 Quarterly Nutritional Reviews indicated that "The Registered Dietitian (RD) completes quarterly nutrition reviews on all residents assessed to be at high nutrition risk. The Food Service and Nutrition Manager (FSNM) completes quarterly reviews on those at low and moderate risk and currently not followed by the

RD."

A) Resident #013 was identified at high nutrition risk by the RD in 2014. The resident was known to have multiple areas pf skin breakdown and poor intake. The FSNM and the RD confirmed the Quarterly review completed on a specified date in 2014 was completed by the FSNM and not the RD as required. (Inspector #130)

B) During this inspection, several critical incidents involving nine residents reporting missing money were inspected concurrently. A review of the home's complaint log for 2014 and 2015 indicated that these complaints had not been documented on the home's complaint log.

A review of the home's Complaints Procedures, #CA-02-14-1, under the procedures section, #5, stated that all complaints, verbal and written must be recorded on the complaints log. If a more detailed report was necessary, it should be completed and attached to the complaints log.

The home had investigated these complaints and documented their investigations of these incidents; however, the home did not document this on the complaint log as per their policy. This information was confirmed by the Administrator. (Inspector #508)

C) During this inspection, it was observed on six occasions, that resident #004's wheelchair had a dried sticky substance in multiple areas of the chair, including the leg pads, the hand rests and the wheels.

During a review of the equipment cleaning schedule, it was identified that this resident's chair had been cleaned at the end of March 2015 and was scheduled to be cleaned at the end of April, 2015. The equipment cleaning protocol had directed staff to clean the residents wheelchairs in between scheduled cleaning dates as required.

It was confirmed with registered staff that the condition of this resident's wheelchair was unacceptable and should have been cleaned when the wheelchair became soiled. (Inspector #508)

D) The home's policy Narcotic and Controlled Drug Count & Ward Count, sec. 6.6, indicated: All narcotic and controlled medications must be accounted for at the end of each shift. Both the nurse handing over (Nurse 1) and taking over (Nurse 2) will sign with the date and time.

On an identified date in 2015, a registered staff discovered five missing narcotic patches from the Extension home area medication room. During the home's investigation into the missing narcotics it was confirmed that registered staff were not consistently counting narcotics at the beginning nor at the end of their shift. This occurred on at least three recorded occasions over a specified period in 2015. The DOC confirmed that registered staff did not comply with the above and titled policy. (Inspector #130)

E) The home's policy Skin Care and Wound Care Program, CN-S-13, indicated: Residents who were assessed with altered skin integrity would have a diet requisition form completed for a dietitian referral. The Dietitian would assess all residents with altered skin integrity and develop interventions related to nutrition and hydration. These interventions would be documented on the care plan and carried out.

On an identified date in 2015 registered staff confirmed that resident #402 had impaired skin integrity to a specified area. The FSNM confirmed a requisition form was not completed or received for a dietitian referral. (Inspector #130) [s. 8. (1) (a),s. 8. (1) (b)]

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. 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:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the residents' nutritional status, including height, weight and any risks relating to nutrition care.

A) The MDS RAI Admission assessment completed on a specified date in 2014, identified resident #013 as high nutritional risk. The Quarterly MDS RAI Assessment completed on a specified date in 2015 indicated the resident remained at high nutritional risk. Registered staff and the clinical record confirmed the areas of skin impairment present on admission had worsened from four to a total of eight areas. The RD confirmed that there was no written nutritional plan developed to address the associated risks related to nutritional care. (Inspector #130)

B) A Nutritional Risk Assessment completed by the RD on an identified date in 2015,

identified resident #002 at high risk nutritional risk. The assessment indicated the resident's nutritional status was declining, their weight showed a significant weight loss and they had multiple areas of skin impairment. The RD confirmed that there was no written nutritional plan to address the associated risks related to nutritional care. (Inspector #130)

C) The Quarterly Nutrition Review policy (CD-05-18-1), June, 2010 identified that the RD completed quarterly nutrition assessments on all residents assessed to be at high risk and based on the results completed or updated the residents' plans of care. During a review of the plan of care for the following residents it was identified that there were no nutrition care plans completed by the RD which included the nutritional status and any risks relating to nutrition care.

i) Resident #001 was identified to be at high nutrition risk, below their ideal weight range, had a weight loss of a specified amount over a four month period in 2015 and poor fluid and food intake.
ii) Resident #003 was identified to be at high nutrition risk, below an ideal body weight, was fed by two different methods and had alterations in skin integrity.
iii) Resident #012 was identified to be at high nutrition risk, had significant weight loss greater than 10 percent in six months and had poor food and fluid intake.

In an interview with the RD it was verified that resident's #001, #003 and #012 did not have a nutrition care plans in place completed by an RD. It was confirmed that the plans of care for residents # 001, #003 and #012 were not based on an assessment of the residents' nutritional status and risks related to nutrition care. (Inspector #583) [s. 26. (3) 13.]

2. The licensee failed to ensure the plan of care was based on an interdisciplinary assessment of the hydration status and any risks relating to hydration.

The Quarterly Nutrition Review policy (CD-05-18-1), June, 2010 identified that the RD completed quarterly nutrition assessments on all residents assessed to be at high risk and based on the results completed or updated the residents' plans of care. During a review of the plan of care for the following residents it was identified that there were no hydration care plans completed by the RD which included the hydration status and any risks relating to hydration.

A) Resident #001 was identified to be at high nutrition risk, below their ideal weight

range, had a weight loss of 4.8 kilograms over a four month period in 2015 and had poor fluid intake.
B) Resident #002 was identified to be at high nutrition risk, below their ideal weight range and had poor fluid intake.
C) Resident #003 was identified to be at high nutrition risk, below an ideal body weight, was fed by two different methods and had alterations in skin integrity.
D) Resident #012 was identified to be at high nutrition risk, had significant weight loss greater than 10 percent in six months and had poor fluid intake.

In an interview with the RD it was verified that resident's #001, #002, #003 and #012 did not have hydration care plans in place completed by the RD. It was confirmed that the plans of care for resident's #001, #002, #003 and #012 were not based on an assessment of the residents' hydration status and risks related to hydration. (Inspector #583) [s. 26. (3) 14.]

3. The licensee failed to ensure the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's special treatments and interventions.

A) Resident #013 had a diagnosis which required a specific treatment routinely. The RAI Coordinator confirmed the need for this treatment was not identified on the written plan of care. (Inspector #130) [s. 26. (3) 18.]

4. The licensee failed to ensure that the Registered Dietitian completed a nutritional assessment for residents whenever there was a significant change in the resident's health condition and that it included the assessment of the resident's nutritional status and hydration status and any risks related to nutrition care and hydration.

A) A review of the plan of care for resident #001 identified they were at high nutrition risk, were below their ideal weight range and had a poor food and fluid intake. The nutrition assessment completed by the RD on a specified date in 2015 identified resident #001 was not meeting their food or fluid requirements based on a review of the food intake records. It was documented that the RD questioned the accuracy of the records and questioned if family was bringing additional food from home. No changes to the nutrition care plan or interventions were put in place at this time. No documented assessment followed that assessed resident #001's fluid and food intake or nutritional status.

A review of the "Oakwood Park Lodge Care Conference Follow Up for Resident" form

completed on an identified date in 2015 identified family raised concerns that the resident was fatigued and had decreased fluid intake and that the plan of action was to involve dietary. A review of the food and fluid intake records for three identified months in 2015 showed daily totals were not analyzed and that resident #001 regularly refused meals and met less than 50% of their fluid requirements. A review of the resident #001's weights showed a weight loss of 4.8 kilograms over a four month period in 2015.

In an interview with the FSNM and RD it was confirmed that resident #001 was not assessed over a four month period in 2015. In an interview with the Administrator it was confirmed that resident #001's nutrition assessment completed on a specified date in 2015 did not include an assessment of the resident's nutrition and hydration status and risks related to nutrition and hydration care. The Administrator also confirmed that there was a significant change in the resident's nutrition prior to the next assessment completed on a specified date in 2015. (Inspector #583) [s. 26. (4)]

5. The licensee failed to ensure that a Registered Dietitian who was a member of the staff of the home, completed a nutritional assessment for all residents on admission.

A) Resident #013 was admitted to the home in 2014, with multiple areas of skin breakdown. The initial nutritional assessment was completed by the FSNM. The resident was not assessed by the RD until several months after the resident's admission. The RD confirmed the resident did not receive a nutritional assessment on admission. (Inspector #130) [s. 26. (4) (a)]

6. The licensee failed to ensure that a Registered Dietitian who was a member of the staff of the home assessed the nutritional status, including height, weight and any risks relating to nutrition care.

A) A review of the plan of care for resident #003 identified the resident was high nutrition risk, below an ideal body weight, was fed orally in combination with an other method and had alterations in skin integrity. A progress note completed in 2014 identified the RD received a phone call from resident #003's Power of Attorney (POA) whom expressed some concerns related to #003's nutritional status and intake. Documentation in a 2014 progress note identified the POA was informed that a full nutritional assessment would be completed to assess resident #003's nutritional status and that the results of the assessment would be emailed to the POA. A review of the plan of care from a specified date in 2014 to a specified date in 2015 identified resident #003's intake volume was increased on a specified date in 2015 but no documentation was found related to an

assessment and evaluation of resident #003's nutritional requirements. In an interview with the RD it was verified a full nutritional assessment to assess resident #003's nutrition status had not been completed between the identified 2014 to 2015 time period. The RD confirmed the POA was not emailed the results of resident #003's assessment as indicated in the plan of care, as the assessment had not been completed. (Inspector #583) [s. 26. (4) (b)]

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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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 failed to ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

A) Resident #007 was observed in their wheelchair on a specified date in 2015 for a period in excess of two hours. The resident was not repositioned during this observed time. A review of the plan of care identified resident #007 had a history of altered skin integrity, was at risk for pressure and stasis ulcers and required total care for positioning by two staff. In an interview with the PSWs it was confirmed that resident #007's safety devices had not been removed and the resident had not been repositioned every two hours. (Inspector #583)

B) According to the clinical record resident #013 had an identified number of areas of skin impairment. On an identified date in 2015, the resident was observed in their chair for a period in excess of two hours. During this time the resident was not repositioned. The resident was interviewed and stated they had not been repositioned and PSW repositioning records confirmed the resident was not repositioned every two hours or more frequently. (Inspector #130) [s. 50. (2) (d)]

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 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 failed to ensure that there was a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition.

A) A review of the plan of care for resident #003 identified they were at high nutrition risk, below and ideal weight range, had areas of altered skin integrity and were fed orally and in combination with another method.. A review of the medication administration record (MAR) over an a 24 day period in 2015 showed there was a record of when resident #003's feeding was started and stopped. In an interview with registered staff it was confirmed that there was no documentation of the volume of food intake resident #003 received over a 24 hour period. During an observation on two identified dates in 2015,it was noted that a specific amount of food volume remained after a scheduled feeding. In an interview with registered staff on two identified dates in 2015 it was confirmed resident #003 only received less than their prescribed amount of food volume. In an interview with the RD it was confirmed that there was no documentation that resident #003 did not receive 100 percent of their prescribed food volume and that there was not a process in place to monitor and evaluate resident #003's intake. (Inspector #583)

B) The "Nutritional Intake" records for residents #012 and #013 were not consistently completed for an identified month in 2015. Both residents were identified at high nutritional risk. The FSNM and the RD confirmed the Nutritional Intake records were not forwarded to them by nursing, they weren't tallied or analyzed by the RD. It was confirmed that there wasn't a process in place for the monitoring and evaluation of nutrition and hydration of residents with identified risks. (Inspector #130)

C) A review of the plan of care for resident #001 identified they were at high nutrition risk, were below their ideal weight range with a weight loss of 4.8 kilograms over a four month period in 2015. The nutrition assessment completed by the RD on an identified date in 2015 identified resident #001 was not meeting their food or fluid requirements based on a review of the food intake records. It was documented that the RD questioned the accuracy of the records and questioned if family was bringing additional food from home. No changes to the nutrition care plan or interventions were put in place at this time. A review of the food and fluid intake records over a three month period in 2015, showed that resident #001 regularly refused breakfast, lunch and dinner and met less than 50% of their fluid requirements. The food and fluid intake daily totals for February, March and April were blank. In an interview the FSNM and RD it was confirmed that resident #001's food and fluid daily totals had not been completed or evaluated in over the identified four month period in 2015 and that the RD had not received any referrals to assess resident #001. It was confirmed a system to monitor and evaluate the food and fluid intake of resident #001 with identified risks related to nutrition and hydration was not in place. (Inspector #583) [s. 68. (2) (d)]

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

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
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.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff did not apply the physical device in accordance with any manufacturer's instructions.

A) It was observed on three identified dates in 2015, that resident #015 was sitting in a wheelchair with a safety device applied incorrectly. The manufacturer's application instructions directed staff to adjust the tightness to ensure they were secure and to check that the straps were secure and would not change if the patient pulls on them. On an identified date in 2015, staff had confirmed that the resident's safety device was incorrectly applied.

The manufacturer's application instructions also indicated that the device must be snug and when checking for proper fit, slide an open flat hand between the device and the patient. The gap noted on these dates was greater than two open flat hands between the device and the resident.

It was confirmed on these identified dates by PSW and registered staff that the resident's device was not applied in accordance with the manufacturer's instructions. (Inspector #508) [s. 110. (1) 1.]

2. The licensee failed to ensure that where a resident was being restrained by a physical device, the resident was released from the physical device and repositioned at least every two hours.

It was observed on an identified date in 2015, that resident #004 was sitting in their wheelchair in the common area with a a safety device applied. Resident #004 could not move independently and was totally dependent on staff for repositioning.

At an identified time, the resident had finished lunch and was taken down to their room to be put back to bed. Shortly after., the Inspector observed a PSW removing the device to prepare the resident for a transfer.

The PSW indicated that they were responsible for resident #004 on this shift and that the last time they had repositioned resident #004 was more than two hours earlier.

It was confirmed by the PSW that the resident had not been released from the physical restraint nor had they been repositioned for a period in an excess of two hours. (Inspector #508) [s. 110. (2) 4.]

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 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 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 failed to ensure that every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs.

A) On an identified date in 2015 resident #200 was observed to be on the toilet with the bathroom and bedroom door fully opened. In an interview with the resident and the PSWs it was identified the resident did not want their door left open and that nursing staff left the room during toileting and left the door open. In an interview with the Administrator it was confirmed that resident #200 was not afforded privacy in treatment and in caring for their personal needs. (Inspector #583)

B) It was observed on an identified date in 2015, that resident #013 was lying in bed on their left side while the PSW was removing their incontinent brief. When the Inspectors

entered the resident's room which was shared with three other residents, the Inspectors observed that the curtain had been pulled to provide privacy to the resident's right side; however, another resident was observed to be in their bed, next to resident #013, on the left side. The curtain on this side had not been pulled to provide privacy to resident #013 when the PSW removed the resident's brief. (Inspector #508)

C) On an identified date in 2015, it was observed by Inspector #611 that two PSWs were transferring a resident using a mechanical lift. The door was open to the room, providing full view of the resident up in the mechanical lift. The staff members were asked by the Inspector to close the resident's door and provide the resident privacy. (Inspector #508) [s. 3. (1) 8.]

2. The licensee failed to ensure that the residents' right to give or refuse consent to any treatment, care or services for which consent was required by law was fully respected and promoted.

A) Resident #001 had a care conference in 2015, where the resident's POA had raised concerns to the multidisciplinary team which included a decrease in food and fluid intake and fatigue. The resident's Physician ordered lab work and in 2015, the resident was started on an anti-depressant. Eight days later, the Physician ordered an increase in the dosage of this medication.

During an interview with the POA, they had indicated that they were not notified to consent to the initiation of the anti-depressant and were only notified when the dosage had been increased eight days after the medication was started. A review of the resident's clinical record had indicated that the POA was informed after the medication was ordered on an identified date in 2015.

It was confirmed by the RAI Coordinator that the resident's POA was not contacted to initially consent to the medication until the staff notified the POA when the dosage of the medication was increased eight days later. (Inspector #508) [s. 3. (1) 11. ii.]

3. The licensee failed to ensure that every resident was afforded the right to 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.

A) On an observed date in 2015, the door to the room labeled "Medical Records" was propped open with a piece of cardboard. The room contained archived medical records, which contained personal health information of residents. Staff confirmed the door was to be kept locked at all times. (Inspector #130) [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs,to ensure that the residents' right to give or refuse consent to any treatment, care or services for which consent is required by law is fully respected and promoted and to ensure every resident is afforded the right to 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident were kept closed and locked.

During a tour of the home on April 14, 2015 a side door on unit 600 that led to a non-secure outside area was observed to be unlatched and unlocked at 1010 hours for an unspecified amount of time. The Administrator and maintenance staff were immediately notified and it was identified that materials added to the door in the winter to prevent draft made the door difficult to latch. The Administrator confirmed the door was unlocked and it was shared two residents on unit 600 were identified to be at elopement risk. (Inspector #583) [s. 9. (1) 1. 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 to ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident are kept closed and locked, to be implemented voluntarily.

WN #9: 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 failed to ensure that residents were provided with food and fluids adequate in quantity.

A) A review of the plan of care for resident #003 identified the resident was high nutrition risk, below an ideal body weight, regularly refused oral intake and had several areas of skin impairment. A review of the RD assessments completed over an identified time period from 2014 to 2015 identified resident #003 was provided 100 percent of their nutritional requirements by a specified method and received a specified textured diet for quality of life and comfort measures only. Resident #003 was ordered a specified volume of a specified food. In an interview with the RD they shared resident #003 would require a different specified amount that the one ordered, based on predictive equations. During an observation on an identified date in 2015, a specified volume of food was not provided to the resident, after the resident's schedule meal time. In an interview with registered staff it was confirmed resident #003 only received less than the ordered volume of food. In an interview with the RD it was confirmed that resident #003 had not received an adequate quantity of calories and protein to meet their nutritional requirements and promote skin healing. (Inspector #583) [s. 11. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are provided with food and fluids adequate in quantity, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions.

A) During a tour of the home on April 14, 2015 it was identified that the Arjo Alenti chair located in the tub room on unit 100 and 400 did not have a safety belt attached to the lift. In an interview with four of the PSWs on April 14, 2015 it was shared that a safety belt was not being used for residents that were transferred into the tub using the Arjo Alenti on unit 100, 400, and 500. Staff shared it had not been communicated to them that this was a requirement. A review of the manufacturer's instructions stated "Place the belt around the resident's waist. Thread the long strap through the buckle and the loop. Tighten the strap and lock.". In an interview with the Administrator on April 14, 2015 it was confirmed that all equipment in the home was not used in accordance with manufacturer's instructions. (Inspector #583) [s. 23.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions., to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring techniques when assisting resident #013.

A) It was observed on an identified date in 2015, at a specific time that one PSW had pushed resident #013 in their chair into resident #013's room. A few minutes later, Inspector #508 entered the resident's room and observed that there was only one PSW in the room providing care to resident #013. The resident was lying on their left side in their bed. The PSW was removing a lift sling and an incontinence brief from under the resident.

Inspector #130 entered the resident's room and the PSW exited the room after removing the brief and the sling. Both Inspector #130 and Inspector #508 identified that there was no other staff present in the resident's room.

The resident had indicated when asked by the Inspectors that the PSW had transferred them from their chair into the bed using the lift equipment independently.

An interview with the Administrator confirmed that it was the home's expectation that there must be two staff present when operating lift equipment to safely transfer residents. (Inspector #508) [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council in developing and carrying out the survey and in acting on its results.

A) During an interview with a member of the Residents' Council, they indicated that they did not know if the Residents' Council was asked to assist in the development and the carrying out of the satisfaction survey. A review of the minutes from the Residents' Council meetings indicated that this was not discussed with the Council.

It was confirmed during an interview with the Recreation Manager that they did not seek out the advice of the Residents' Council when developing and carrying out the satisfaction survey. (Inspector #508) [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee seeks the advice of the Residents' Council in developing and carryout the survey and in acting on its results, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to comply with the conditions to which the licence was subject as outlined in section 4.1 Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in applicable policy". The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care."

(A) Nursing staff (PSWs) were observed completing laundry duties (delivering personal laundry to resident rooms) on each day of this inspection. The Administrator confirmed that this duty was part of their job routine and that PSW staff were paid from Nursing and Personal Care (NPC) Funds. [s. 101. (4)] (Inspector #130) [s. 101. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure compliance with the conditions to which the licence is subject as outlined in section 4.1 Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in applicable policy". The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

A) During this inspection it was observed that emergency stat drugs were stored in a locked tackle box, which was located in the DOC office. On April 14, 2014 at 1145 hours the door to the DOC was ajar, the room was unsupervised and the emergency stat box was observed sitting on a file cabinet. The stat box was accessible to anyone passing by the door. Two Inspectors were able to enter the room, remove the tackle box and deliver it to the Administrator's office without incident. Not all areas where drugs were stored were kept locked at all times. (Inspector #130) [s. 130. 1.]

2. The licensee failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

A) On January 27, 2015 the home reported that five narcotic patches went missing from the Extension home area medication room. A registered staff admitted leaving the keys to the medication room in an unlocked drawer, located outside of the medication room. This information was confirmed by the DOC. (Inspector #130) [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored are kept locked at all times, when not in use and to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #15: 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 failed to ensure that staff participated in the implementation of the infection prevention and control program.

A) It was identified on April 15, 2015, in room #611, that in the bathroom shared by four residents that there was a toothbrush, comb, k-basin and a denture cup on top of the counter with no labels to indicate which residents they belonged to. In room #504, in a bathroom shared by four residents there was a stick deodorant, a comb, two hair brushes and a toothbrush without labels to identify which resident they belonged to.

It was confirmed by registered staff that these personal items should have been labeled in the residents shared bathrooms to minimize the risk of cross contamination.

B) It was observed by Inspector #611 on April 22, 2015 that a PSW entered the garden room with a lift battery in their hand. They were wearing gloves as they entered the room. The battery charging docking station was located in this room. They proceeded to switch out the battery, took a new one and left the room. The PSW was then observed entering an identified resident room. As the Inspector walked by room, they observed the PSW still wearing the gloves; the time span would not have allowed for the gloves to be changed. (Inspector #508) [s. 229. (4)]

Additional Required Actions:

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

WN #16: 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 was a safe and secure environment for its residents.

A) On April 14, 2015 at 1040 hours, an unlocked maintenance cart was left unsupervised in the "Main" hallway. The cart contained a variety of tools, power tools and hazardous chemicals. Registered staff confirmed the cart should have been supervised or locked when not in use. (Inspector #130) [s. 5.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was assessed using a clinically appropriate instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required it.

A) Resident #016 had a change in their level of continence from being continent of bladder in 2014 to frequently incontinent later in 2014, due to a change in their condition. A review of the resident's clinical record indicated that the resident was not reassessed when there was a change in their continence.

It was confirmed by the RAI Coordinator that the resident was not reassessed using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition of the resident was required. (Inspector #508) [s. 51. (2) (a)]

Issued on this 5th day of August, 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) :	GILLIAN TRACEY (130), KELLY HAYES (583), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2015_323130_0007
Log No. / Registre no:	H-002168-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 27, 2015
Licensee / Titulaire de permis :	MARYBAN HOLDINGS LTD 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	OAKWOOD PARK LODGE 6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LeAnne Ryan

To MARYBAN HOLDINGS LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 ensure that the care set out in the plans of care for all resident's, including residents #007, #013, #200, #300 and #401, is provided to the resident as specified in the plan, specifically related to nutritional care, restraint use, safe transferring and toileting.

Grounds / Motifs :

1. Previously issued on March 14, 2014 as a VPC.

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

A) On a specified date in 2015, resident #401 sustained a witnessed fall, which resulted in injury. The resident's plan of care identified the need for a safety device, to prevent self-ambulation. Staff interviewed and the critical incident notes confirmed at the time of the incident, the safety device was not fastened. Care was not provided in accordance with the resident's plan of care. (Inspector #130)

B) On a specified date in 2015 resident #200 was observed to be left unattended on the toilet with the bathroom and bedroom door fully opened. In an interview with the front line nursing staff it was shared the resident was not supposed to be left unattended during toileting. A review of the care plan identified resident #200 was assessed to be totally dependent for toileting and required two person physical assistance for the task. In an interview with the registered staff it was confirmed that the care set out in the plan of care was not provided as specified in the plan.(Inspector #583)

C) On a specified date in 2015, it was observed that one PSW entered resident #013's room pushing the resident in their chair. A few minutes later, it was observed that the resident was lying in their bed and there was only one PSW in the resident's room. Resident #013 had indicated to Inspector #130 and Inspector #508 that one staff person transferred them using a mechanical lift from the resident's chair to their bed, independently.

A review of the resident's written plan of care indicated that the resident required total assistance of two staff using a mechanical lift for all transfers.

It was confirmed during an interview with registered staff that care was not provided to resident #013 as specified in the plan of care. (Inspector #508)

D) On a specified date in 2015, resident #300 was observed seated in their wheelchair with a loose fitting safety device applied. The resident was unable to unfasten the device on command. The DOC assessed the device at the request of Inspector #130 and confirmed the device was not properly applied. The DOC spoke with the registered staff about the device and advised the Inspector that the resident was not authorized to have the device applied. The plan of care did not identify the need for a safety device. Care was not provided as specified in the plan of care. (Inspector #130)

E) A review of the plan of care for resident #007 identified they were at high nutrition risk, had variable oral intake and required an individualized diet plan. Resident #007 was ordered a specialized diet by the RD. A review of the written care plan interventions created by the RD, identified the RD would liaise with the specialized RD as required. The RD assessments completed from 2014 to 2015 did not identify the RD liaised with the specialized RD. In an interview with the RD it was confirmed the RD had not communicated with the specialized RD in regards to resident #007. It was shared that information from the specialized RD including resident #007's blood work, fluid balance, dry weights and education provided by the specialized RD could have been valuable when completing the nutrition assessments. It was identified this information would help to assess whether resident #007 nutritional requirements were being met with their individualized diet plan. (Inspector #583) [s. 6. (7)]
(583)

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 : Aug 31, 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 : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the home's policies, including Quarterly Nutritional Reviews CD-05-18-1 , Narcotic and Controlled Drug Count & Ward Count, sec. 6.6, Complaints Procedures CA-02-14-1, sec 5, Skin Care and Wound Care Program, CN-S-13 and the Equipment Cleaning Protocol are complied with.

Grounds / Motifs :

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

The home's policy CD-05-18-1 Quarterly Nutritional Reviews indicated that "The Registered Dietitian (RD) completes quarterly nutrition reviews on all residents assessed to be at high nutrition risk. The Food Service and Nutrition Manager (FSNM) completes quarterly reviews on those at low and moderate risk and currently not followed by the RD."

A) Resident #013 was identified at high nutrition risk by the RD in 2014. The resident was known to have multiple areas pf skin breakdown and poor intake. The FSNM and the RD confirmed the Quarterly review completed on a specified date in 2014 was completed by the FSNM and not the RD as required. (Inspector #130)

B) During this inspection, several critical incidents involving nine residents

reporting missing money were inspected concurrently. A review of the home's complaint log for 2014 and 2015 indicated that these complaints had not been documented on the home's complaint log.

A review of the home's Complaints Procedures, #CA-02-14-1, under the procedures section, #5, stated that all complaints, verbal and written must be recorded on the complaints log. If a more detailed report was necessary, it should be completed and attached to the complaints log.

The home had investigated these complaints and documented their investigations of these incidents; however, the home did not document this on the complaint log as per their policy. This information was confirmed by the Administrator. (Inspector #508)

C) During this inspection, it was observed on six occasions, that resident #004's wheelchair had a dried sticky substance in multiple areas of the chair, including the leg pads, the hand rests and the wheels.

During a review of the equipment cleaning schedule, it was identified that this resident's chair had been cleaned at the end of March 2015 and was scheduled to be cleaned at the end of April, 2015. The equipment cleaning protocol had directed staff to clean the residents wheelchairs in between scheduled cleaning dates as required.

It was confirmed with registered staff that the condition of this resident's wheelchair was unacceptable and should have been cleaned when the wheelchair became soiled. (Inspector #508)

D) The home's policy Narcotic and Controlled Drug Count & Ward Count, sec. 6.6, indicated: All narcotic and controlled medications must be accounted for at the end of each shift. Both the nurse handing over (Nurse 1) and taking over (Nurse 2) will sign with the date and time.

On an identified date in 2015, a registered staff discovered five missing narcotic patches from the Extension home area medication room. During the home's investigation into the missing narcotics it was confirmed that registered staff were not consistently counting narcotics at the beginning nor at the end of their shift. This occurred on at least three recorded occasions over a specified period in 2015. The DOC confirmed that registered staff did not comply with the above

and titled policy. (Inspector #130)

E) The home's policy Skin Care and Wound Care Program, CN-S-13, indicated: Residents who were assessed with altered skin integrity would have a diet requisition form completed for a dietitian referral. The Dietitian would assess all residents with altered skin integrity and develop interventions related to nutrition and hydration. These interventions would be documented on the care plan and carried out.

On an identified date in 2015 registered staff confirmed that resident #402 had impaired skin integrity to a specified area. The FSNM confirmed a requisition form was not completed or received for a dietitian referral. (Inspector #130) [s. 8. (1) (a),s. 8. (1) (b)]

(130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 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. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
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.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall ensure the following:

That the plan of care for all residents, including residents #001, #002, #003, #-12 and #013, is based on, at a minimum, interdisciplinary assessment of the following with respect to the residents' nutritional status, including height, weight and any risks relating to nutrition care and;

That the plan of care is based on an interdisciplinary assessment of the hydration status and any risks related to hydration.

Grounds / Motifs :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the residents' nutritional status, including height, weight and any risks relating to nutrition care.

A) The MDS RAI Admission assessment completed on a specified date in 2014, identified resident #013 as high nutritional risk. The Quarterly MDS RAI Assessment completed on a specified date in 2015 indicated the resident remained at high nutritional risk. Registered staff and the clinical record confirmed the areas of skin impairment present on admission had worsened from four to a total of eight areas. The RD confirmed that there was no written nutritional plan developed to address the associated risks related to nutritional care. (Inspector #130)

B) A Nutritional Risk Assessment completed by the RD on an identified date in 2015, identified resident #002 at high risk nutritional risk. The assessment indicated the resident's nutritional status was declining, their weight showed a significant weight loss and they had multiple areas of skin impairment. The RD confirmed that there was no written nutritional plan to address the associated risks related to nutritional care. (Inspector #130)

C) The Quarterly Nutrition Review policy (CD-05-18-1), June, 2010 identified that the RD completed quarterly nutrition assessments on all residents assessed to be at high risk and based on the results completed or updated the residents' plans of care. During a review of the plan of care for the following residents it was identified that there were no nutrition care plans completed by the RD which

included the nutritional status and any risks relating to nutrition care.

i) Resident #001 was identified to be at high nutrition risk, below their ideal weight range, had a weight loss of a specified amount over a four month period in 2015 and poor fluid and food intake.
ii) Resident #003 was identified to be at high nutrition risk, below an ideal body weight, was fed by two different methods and had alterations in skin integrity.
iii) Resident #012 was identified to be at high nutrition risk, had significant weight loss greater than 10 percent in six months and had poor food and fluid intake.

In an interview with the RD it was verified that resident's #001, #003 and #012 did not have a nutrition care plans in place completed by an RD. It was confirmed that the plans of care for residents # 001, #003 and #012 were not based on an assessment of the residents' nutritional status and risks related to nutrition care. (Inspector #583) [s. 26. (3) 13.]
(130)

2. The licensee failed to ensure the plan of care was based on an interdisciplinary assessment of the hydration status and any risks relating to hydration.

The Quarterly Nutrition Review policy (CD-05-18-1), June, 2010 identified that the RD completed quarterly nutrition assessments on all residents assessed to be at high risk and based on the results completed or updated the residents' plans of care. During a review of the plan of care for the following residents it was identified that there were no hydration care plans completed by the RD which included the hydration status and any risks relating to hydration.

A) Resident #001 was identified to be at high nutrition risk, below their ideal weight range, had a weight loss of 4.8 kilograms from January to April 2015 and had poor fluid intake.
B) Resident #002 was identified to be at high nutrition risk, below their ideal weight range and had poor fluid intake.
C) Resident #003 was identified to be at high nutrition risk, below an ideal body weight, was on a tube feed in combination with oral diet and had alterations in skin integrity.
D) Resident #012 was identified to be at high nutrition risk, had significant weight loss greater than 10 percent in six months and had poor fluid intake.

In an interview with the RD on April 24, 2015 it was verified that resident's #001, #002, #003 and #012 did not have hydration care plans in place completed by the RD. It was confirmed that the plans of care for resident's #001, #002, #003 and #012 were not based on an assessment of the residents' hydration status and risks related to hydration. (Inspector #583)
(583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(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

(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).

Order / Ordre :

The licensee shall ensure that residents, including residents #007 and #013 who are dependent on staff for repositioning are repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

A) Resident #007 was observed in their wheelchair on a specified date in 2015 for a period in excess of two hours. The resident was not repositioned during this observed time. A review of the plan of care identified resident #007 had a history of altered skin integrity, was at risk for alteration in skin and required total care for positioning by two staff. In an interview with the PSWs it was confirmed that resident #007's safety devices had not been removed and the resident had not been repositioned every two hours. (Inspector #583)

B) According to the clinical record resident #013 had an identified number of areas of skin impairment. On an identified date in 2015, the resident was observed in their chair for a period in excess of two hours. During this time the resident was not repositioned. The resident was interviewed and stated they had not been repositioned and PSW repositioning records confirmed the resident was not repositioned every two hours or more frequently. (Inspector #130) [s. 50. (2) (d)]

Grounds / Motifs :

1. The licensee failed to ensure that the resident who was dependent on staff for repositioning had been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

(130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that there is a system to monitor and evaluate the food and fluid intake of residents, including residents #001, #003, #012 and #013, with identified risks related to nutrition. The plan shall include but not be limited to the following:

1. Quality monitoring activities to ensure the completion and analysis of nutritional intake records.

Grounds / Motifs :

1. The licensee failed to ensure that there was a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition.

A) A review of the plan of care for resident #003 identified they were at high nutrition risk, below and ideal weight range, had areas of altered skin integrity and were fed orally and in combination with another method.. A review of the

medication administration record (MAR) over a 24 day period in 2015 showed there was a record of when resident #003's nutrition was started and stopped. In an interview with registered staff it was confirmed that there was no documentation of the volume of food intake resident #003 received over a 24 hour period. During an observation on two identified dates in 2015, it was noted that a specific amount of food volume remained after a scheduled feeding. In an interview with registered staff on two identified dates in 2015 it was confirmed resident #003 received less than their prescribed amount of food volume. In an interview with the RD it was confirmed that there was no documentation that resident #003 did not receive 100 percent of their prescribed food volume and that there was not a process in place to monitor and evaluate resident #003's intake. (Inspector #583)

B) The "Nutritional Intake" records for residents #012 and #013 were not consistently completed for an identified month in 2015. Both residents were identified at high nutritional risk. The FSNM and the RD confirmed the Nutritional Intake records were not forwarded to them by nursing, they weren't tallied or analyzed by the RD. It was confirmed that there wasn't a process in place for the monitoring and evaluation of nutrition and hydration of residents with identified risks. (Inspector #130)

C) A review of the plan of care for resident #001 identified they were at high nutrition risk, were below their ideal weight range with a weight loss of 4.8 kilograms over a four month period in 2015. The nutrition assessment completed by the RD on an identified date in 2015 identified resident #001 was not meeting their food or fluid requirements based on a review of the food intake records. It was documented that the RD questioned the accuracy of the records and questioned if family was bringing additional food from home. No changes to the nutrition care plan or interventions were put in place at this time. A review of the food and fluid intake records over a three month period in 2015, showed that resident #001 regularly refused breakfast, lunch and dinner and met less than 50% of their fluid requirements. The food and fluid intake daily totals for February, March and April were blank. In an interview the FSNM and RD it was confirmed that resident #001's food and fluid daily totals had not been completed or evaluated in over the identified four month period in 2015 and that the RD had not received any referrals to assess resident #001. It was confirmed a system to monitor and evaluate the food and fluid intake of resident #001 with identified risks related to nutrition and hydration was not in place. (Inspector #583) [s. 68. (2) (d)] (583)

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 : Aug 31, 2015

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall ensure ensure that all seat belts are applied in accordance with the manufacturer's application instructions.

Grounds / Motifs :

1. The licensee has failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

A) It was observed on three identified dates in 2015, that resident #015 was sitting in a wheelchair with a safety device applied incorrectly. The manufacturer's application instructions directed staff to adjust the tightness to ensure they were secure and to check that the straps were secure and would not change if the patient pulls on them. On an identified date in 2015, staff had confirmed that the resident's safety device was incorrectly applied.

The manufacturer's application instructions also indicated that the device must be snug and when checking for proper fit, slide an open flat hand between the device and the patient. The gap noted on these dates was greater than two open flat hands between the device and the resident.

It was confirmed on these identified dates by PSW and registered staff that the resident's device was not applied in accordance with the manufacturer's instructions. (Inspector #508) [s. 110. (1) 1.]

2. The licensee failed to ensure that where a resident was being restrained by a physical device, the resident was released from the physical device and repositioned at least every two hours.

It was observed on an identified date in 2015, that resident #004 was sitting in their wheelchair in the common area with a a safety device applied. Resident #004 could not move independently and was totally dependent on staff for repositioning.

At an identified time, the resident had finished lunch and was taken down to their room to be put back to bed. Shortly after., the Inspector observed a PSW removing the device to prepare the resident for a transfer.

The PSW indicated that they were responsible for resident #004 on this shift and that the last time they had repositioned resident #004 was more than two hours earlier.

It was confirmed by the PSW that the resident had not been released from the physical restraint nor had they been repositioned for a period in an excess of two hours. (Inspector #508) [s. 110. (2) 4.] (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

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

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

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

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

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

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

Issued on this 27th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GILLIAN TRACEY

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