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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 20, 2016;	2016_343585_0007 (A2)	010808-16	Resident Quality Inspection

Licensee/Titulaire de permis

PARK LANE TERRACE LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

PARK LANE TERRACE
295 GRAND RIVER STREET NORTH PARIS ON N3L 2N9

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

LEAH CURLE (585) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Change to compliance date for CO #004

Issued on this 20 day of June 2016 (A2)

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

Original report signed by the inspector.

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LEAH CURLE (585) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): April 18, 19, 20, 21, 22, 26, 27, 28, 29 and May 3, 2016

Concurrent with the resident quality inspection (RQI), 10 additional inspections were completed, including four complaints: log #: 028477-15 related to staffing, 001320-16 and 004884-16 related to resident assessments, 010948-16 related to hospital transfer, two critical incident system (CIS) inspections: log #: 005858-14 related to medications and 007216-16 related to discharge of resident and four follow-up inspections for compliance orders (CO) log #: 027829-15 to inspection 2015_343585_0015/H-003372-15 CO #001 regarding continence care and bowel management [r. 51. (2) (h) (i)], 027830-15 to inspection 2015_343585_0015/H-003374-15 CO #002 regarding to bed rails [r. 51. (2) (h) (i)], 027831-15 to 2015_343585_15/H-003375-15 CO#003 regarding safe storage of drugs [r. 129. (1) (a) (ii)] and 027832-15 to 2015_343585_15/H-003376-15 CO#004 regarding safe transferring and positioning [r. 36.].

During the course of the inspection, the inspector(s) spoke with residents, families, registered nursing staff, personal support workers (PSWs), a physician, dietary staff, housekeeping staff, maintenance, resident assessment instrument (RAI) coordinator, programs director, Food Service Manager, Registered Dietitian (RD), Director of Care (DOC) and the Administrator.

The inspectors also toured the home, observed care and services provided to residents and reviewed records including but not limited to: resident clinical

health records, menus, log, schedules and training records, meeting minutes, policies and procedures, program evaluations and investigation records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dining Observation

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **17 WN(s)**
- **11 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) On an identified date in April 2016, resident #008's bed was observed with two bed rails raised. A review of their clinical health record revealed that a bed rail assessment was completed in July 2015 which stated they required the use of one bed rail as a personal assistance services device (PASD). Interview with personal support worker (PSW) #105 reported the resident used two bed rails for repositioning and bed mobility. Interview with registered staff #104 stated the bed rails were changed in October 2015 and confirmed an assessment of the bed rails being used at the time of the inspection was not completed.

B) On identified dates in April 2016, resident #010 was observed in bed with two bed rails raised. Review of the their clinical record revealed no assessment was completed for the use of the bed rails. Interview with the resident and registered staff #101 stated they used two bed rails for transferring and bed mobility. Registered staff #101 confirmed an assessment of the bed rails was not completed.

C) On an identified date in April 2016, resident #007's bed was observed with two bed rails raised. Review of their clinical health record revealed that a bed rail assessment was completed in October 2014 which stated they required one bed rail for transferring and bed mobility. Interview with registered staff #104 stated the resident's bed rails were changed in October 2015 and confirmed an assessment of the two bed rails being used was not completed.

D) On an identified date in April 2016, resident #076 was provided with a change of bed with bed rails; however, the bed system was not tested for zones of entrapment until the next day. Housekeeping staff #116 who completed the assessment stated the bed system failed zones two and four and confirmed that the resident's bed system was not tested for zones of entrapment prior to the resident sleeping one night with the bed rails in place. [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: 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 and positioning devices or techniques when assisting residents.

A) Resident #068's written plan of care as well as a Safe Lift and Transfer (S.A.L.T.) assessment completed in April 2016 identified that they were to be assessed daily and transferred with one or two person assist with a transferring device.

On an identified date in April 2016, the resident was observed being transferred with two staff but the staff did not use a transferring device. Interview with PSW #117 stated the resident was to be transferred with the device and confirmed they did not adhere to their designated transfer status. Interview with registered staff #101 stated that staff were to follow the logo at bedside and kardex which indicated a transfer device was to be used with all transfers and confirmed that staff did not use safe transferring and positioning devices or techniques when assisting resident #068.

B) Resident #043's written plan of care as well as a S.A.L.T. assessment completed in February 2016 identified that they required two staff assistance for transferring with a lift device and transfer device, which was to be assessed daily and was reflected on signs posted in the resident's room.

On an identified date in April 2016, resident #043 requested the assistance of staff to transfer, PSW #141 assisted the resident to a chair. Interview with PSW #141 who confirmed that on that shift, they provided supervision only with one staff present. Interview with PSW #145 confirmed that the resident required two person assistance for transfers with a transfer device. The resident was not transferred according to the designated lift/transfer status in their plan of care, as required in the homes "Minimal Lift Policy". [s. 36.]

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. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

A) On April 18, 2016, at 1524 hours, the medication room door was observed to be propped open and a medication cart was located inside the room. Registered staff #133 was seated in the chart room beside the medication room. The Long-Term Care (LTC) Homes Inspector was able to enter nurses station and medication room, without registered staff #133 being aware. Medication cupboards in the medication room and drawers in the medication cart were opened. Over ten minutes later, registered staff #133 noticed the LTC Homes Inspector in the medication room and confirmed that the cart and room should have been locked when unattended.

B) On April 20, 2016, in the afternoon, registered staff #134 was observed dispensing and administering medications to residents on Heritage South home area. From 1530 hours, for approximately 10 minutes, registered staff #134 dispensed and then administered medications to three residents in their rooms. The medication cart was left in the hallway while registered staff #134 entered the resident rooms. The cart was not locked at any time during the observations. Interview with registered staff #134 confirmed the cart was left unlocked when unattended.

C) On April 28, 2016 at approximately 1400 hours, a medication cart was observed in front of the Heritage front desk, facing the residents lounge, was noted to be unlocked. The LTC Homes Inspector was able to approach and open the medication cart drawers without any registered staff becoming aware. Resident and families were observed visiting in the immediate areas around the cart. Registered staff #100 confirmed that the cart was left unlocked by mistake.

D) On April 28, 2016, at 1515 hours, the medication cart located behind the front desk of Heritage nursing area was observed unlocked. From 1515 to 1525 hours, registered staff in the Heritage workroom were unaware that the LTC Homes Inspector had access to the cart and was opening the medication cart drawers. During the observation, non-registered staff were observed behind the front desk. At 1525 hours, registered staff #100 confirmed that the cart was not locked and secured when unattended. [s. 129. (1) (a) (ii)]

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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that their continence care and bowel management program at a minimum, provided for strategies to maximize residents'

independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

Review of the home's Incontinent System Policy, effective October 2015, identified set criteria for the use of pull ups which included a resident with light to moderate incontinence at a level where they only required one to two pull ups in 24 hours. Further, they had to be able to toilet themselves independently without any assistance of staff, complete all aspects of care (managing clothing, the act of toileting and perineum care) and have no bowel incontinence. If the resident and family were not satisfied with the product deemed appropriate for use, they could purchase their own, the DOC would assist them with that process and their plan of care would include documentation as to why they considered the product offered as inadequate.

Review of the Resident Profile Worksheets, which listed the type of incontinence product residents required on all three shifts in all home areas, dated April 2016, revealed that ten residents were providing their own pull up product. No residents were identified on the worksheets as using a pull up product provided by the home, as confirmed by the DOC. The DOC stated that the home provided classic style Tena pull up incontinence product with an absorbance of four out of eight, in two sizes - medium and extra- large, that staff were aware of the product and were available to residents who met the criteria above.

During the inspection, registered staff #107, registered staff #126, registered staff #156 and registered staff #134 as well as PSW #106, PSW #108, PSW #109, PSW #112, PSW #113, PSW #117, PSW #135, PSW #151 and PSW #152, four of whom were Tena product representatives on three of the four home areas, all reported that the home did not supply pull up continence products for residents. Further, staff reported that any resident who required or preferred a pull up product was required to purchase the product or the home would order the product and the family was billed.

The DOC confirmed that their incontinence system policy related to the criteria for a pull up style product did not provide strategies to maximize residents' independence, comfort and dignity. [s. 51. (1) 4.]

2. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was

implemented.

A) Resident #003's plan of care identified they were incontinent and required assistance of staff to provide care. Specifically, the plan directed staff to check and change resident every two hours and on rounds during nights. Further, it also identified the resident had altered skin integrity.

On an identified date in April 2016, resident #003 was observed in bed with their incontinence product completely soaked with urine, as well as a pad underneath them. Approximately half an hour later, one staff went into the resident's room and shortly after, registered staff #132 administered medication to resident. The resident was not provided continence care until an hour and forty five minutes following the initial observation. Interview with PSW #122 and PSW #131 confirmed they had visually observed resident in bed at the beginning of their shift; however, did not check the resident's incontinence product when they came on shift. The PSWs also confirmed they did not provide continence care for four hours. PSW #122 confirmed that the resident was soaked with urine when their incontinence product was changed and should have been changed first when staff arrived. Interview with PSW #147 who worked the shift prior confirmed the resident was checked at two hours before the next shift change. On an identified date in April 2016, the resident was not checked and changed for incontinence every two hours, and the plan to keep the resident clean and dry was not implemented. [s. 51. (2) (b)]

3. The licensee failed to ensure that residents were provided with a range of continence care products that,
(i) were based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promoted resident comfort, ease of use, dignity and good skin integrity,
(iv) promoted continued independence wherever possible, and
(v) were appropriate for the time of day, and for the individual resident's type of incontinence.

A) Resident #074's plan of care indicated they required assistance for toileting and wore incontinent products. Review of the Resident Profile Worksheet, as well as the continence logo posted at bedside, identified they wore their own pull up style incontinence product. Interview with PSW #117 stated when the resident was admitted to the home, the family had provided a pull up style product; however, they ran out of their product and the resident was now wearing a different type of

incontinence product as the home did not provide pull up style products. The resident stated they were wearing their own pull up product but were changed to a different product as they were told the home did not provide pull up products and indicated that they would prefer to wear a pull up style product as it allowed them to be more independent with toileting. Interview with registered staff #101 stated that the resident was using a pull up product that the family provided; however, was changed to a different product as the home did not provide a pull up style product and confirmed the resident was not assessed on their individual needs and preferences when they were changed from a pull up style product. The home did not provide a continent care product that promoted resident #074's comfort, ease of use, and independence.

B) Resident #072's plan of care indicated they required incontinence products. Interview with PSW #152 reported that the resident initially wore a pull up style product, which the resident supplied; however, when the pull up product supply was finished they were informed by the DOC to use a different incontinence product. Interview with the resident who stated they were using the products provided by the home; however, found they did not fit well and they preferred a pull up style product. The resident stated they were told by the home that they did not provide a pull up style product and they would have to buy the product themselves. Interview with the DOC confirmed that the resident was not provided with a pull up product from the home and was not assessed on their individual needs and preferences when they were changed from a pull up style product to a different incontinence product.

C) Resident #062's plan of care identified they were incontinent and required supervision with some aspects of toileting, but would self-transfer to the bathroom. The resident reported that they used a pull up incontinence product which was their preference, that their family bought them as the home did not provide pull up style product. Interview with resident's family who stated the home showed them the incontinence products that they provided upon admission and they did not offer a pull up product, so the family continued to purchase them to maintain the resident's independence and comfort with toileting. Interview with registered staff #126 and PSW #151 who stated the home did not provide pull up style incontinence products and that resident's family was paying for the product and bringing it into the home. Interview with the DOC confirmed that the resident was not provided with a pull up style product from the home and was not assessed on their individual needs and preferences and the home was not providing a continent care product that promoted the resident's comfort, ease of use and independence. [s. 51. (2) (h) (i)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 004

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 and ensuring that the continence care and bowel management program must, at a minimum, provide for the following strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids and each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that they did not cause or permit anyone to make a

charge or accept such a payment on the licensee's behalf.

Ontario Regulation 79/10 section 245 paragraph 1 identified the following:
The following charges are prohibited for the purposes of paragraph 4 of subsection 91(1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, 1. A local health integration network under section 19 of the Local Health System Integration Act, 2006 including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act".

The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies.

The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCA or accommodation charges received under the LTCA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCA"

Section 51(2) of the Regulation under the LTCA identified the following:
"51. (2) Every licensee of a long-term care home shall ensure that, (f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and (h) residents are provided with a range of continence care products that, (i) are based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible and (v) are appropriate for the time of day, and for the individual resident's type of incontinence".

If a resident was assessed to require a pull up style incontinent product then it shall be provided as part of the range of continence care products to be provided at no charge by the home.

The licensee permitted the resident's representative to make a charge or accept a payment on the licensee's behalf for continence care products, which they received funding from the local health integration network under the service accountability agreement.

A) Resident #064's plan of care identified they required supervision and assistance for toileting and used a pull up style incontinence product. Interview with PSW #113 stated that the home did not provide pull up style products but they ordered the pull up product for the resident and the bill was sent to the family. Interview with the resident's substitute decision maker (SDM) stated that they were unaware the home provided pull up style products and confirmed that the home ordered the pull up style product from Cardinal Health and they were paying for the product for an identified period of time. Interview with the DOC confirmed that the resident wore a pull up style incontinence product which was ordered by the home; however, the bill was charged to the family by Cardinal Health.

B) Resident #070's plan of care indicated they required assistance for toileting and used a pull up style incontinent product. Interview with PSW #151 and the resident stated they were able to toilet themselves but required assistance some aspects of care. PSW #151 also stated that the home did not provide pull up style products and that the families paid for the product. Interview with the DOC confirmed that the resident wore a pull up style incontinence product which was ordered by the home; however, the bill was charged to the family by Cardinal Health.

C) Resident #074's plan of care identified they required assistance for toileting and used a pull up style incontinent product. The resident stated that they had been wearing a pull up type product that they provided but they did not have any more so they were now using different type of incontinence product provided by the home. The resident's family reported in an interview that when the resident was admitted to the home, the home stated they provided various continence products; however, did not specify a pull up type product. Further, they reported the resident would be reassessed when their pull up products ran out. The family stated they were aware the incontinence product was changed non-pull-up type product; however, the resident did not like the change in product, preferred a pull up style

product and that the resident asked if they would purchase a pull up product for them. The family reported they purchased pull up style incontinent product for the resident. Interview with PSW #117 stated that the resident was wearing a pull up product which the family provided but when the supply was finished, they changed to a different product as the home did not supply pull up incontinence products. Registered staff #101 confirmed the resident was not provided with a pull up style incontinent product from the home and family were still buying the pull up style incontinent product for the resident. [s. 91. (4)]

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 LTCHA, 2007, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out, the planned care for the resident.

A) Resident #062's plan of care indicated they required supervision for toileting but would self-transfer at times and required continence products. Interview with PSW #113 stated the resident wore specific incontinence products; however, the kardex as well as a bed side logo used to provide direction for care did not identify what

product they required. Interview with registered staff #126 stated they wore two products and confirmed the written plan of care did not include what type of continence care product the resident required.

B) Resident #074's plan of care indicated they required assistance for toileting and wore incontinent products. Interview with PSW #117 and registered staff #101 stated the resident wore a specific incontinence products and registered staff #101 confirmed the written plan of care did not identify what type of continence care product the resident required.

C) Resident #072's plan of care identified they required incontinence products. Interview with PSW #152 and registered staff #156 stated the resident wore specific type of incontinence product. Review of the written plan of care did not identify what type of continence care product the resident needed, which was confirmed by registered staff #156. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that set out clear direction to staff and others who provided direct care to the resident.

A) Resident #080's plan of care stated a goal to maintain the ability to feed with supervision only and an intervention to provide extensive to total assistance for eating. During two meals on two identified dates in April 2016, resident #080 was not provided assistance when eating. During one meal on an identified date in April 2016, they received extensive assistance. PSW #122 reported the resident required supervision when eating. Registered staff #119 reported they required total assistance with eating; however at times declined assistance. Registered staff #101 confirmed the written plan of care did not provide clear direction regarding the resident's level of assistance required for eating.

B) Resident #068's written plan of care and kardex, used by staff to provide direction for care, stated they required one to two person assistance for transfers with a transfer device and assess daily. A S.A.L.T. assessment, completed in April 2016, also indicated they required one or two assist with a transfer device and assess daily. The S.A.L.T. logo posted in the resident's room indicated they were to be transferred with two person using a different transfer method. Interview with PSW #117 stated the resident was transferred with one to two person with a transfer device. Interview with registered staff #101 stated resident was transferred by one or two staff with a transfer device, that the kardex and the logo

were inconsistent with each other and confirmed the written plan of care did not set out clear direction to staff related to the resident's transfer requirements.

C) Resident #008's written plan of care indicated under the transfer and bed mobility focus that they required one bed rail when in bed; however, under risk of falls focus the plan stated they required two rails. On multiple occasions during the inspection, the resident's bed was observed with two bed rails raised. Interview with PSW #105 stated the resident had two bed rails raised when in bed. Interview with registered staff #104 confirmed there was no clear direction to staff related to bed rails. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) Resident #042 identified they had a preferred time to receive assistance out of bed. Review of the resident's plan of care did not include any sleep preferences. Interviews with PSW #131 and PSW #122 confirmed that the resident had a preferred time to receive assistance out of bed and registered staff #132 confirmed their written plan of care did not include directions to staff for the resident's sleep patterns and preferences. [s. 6. (2)]

4. The licensee failed to ensure that staff and others involved in different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) Resident #007's Minimum Data Set (MDS) assessment completed in December 2015 stated they had a regular bowel elimination pattern during the assessment period: at least one movement every three days. Point of Care (POC) documentation completed by PSWs during the review period indicated the resident was not having regular bowel movements. PSW #135 reported that the resident required the bowel routine and registered staff #104 confirmed the MDS assessment in December 2015 was not consistent with POC documentation completed by PSW's.

B) Resident #072's MDS assessment completed in March 2016 indicated they were usually continent of bladder and bowel. Review of their Bowel and Bladder Assessment completed in March 2016 identified they were continent of bowel and bladder. Interview with the registered staff # 156 stated that during the MDS assessment period they were usually continent of both bowel and bladder and

confirmed that the two assessments were not consistent or complemented each other.

C) Resident #074's MDS assessment, completed in April 2016, identified they were usually continent of bladder. Review of their Bowel and Bladder Assessment completed in April 2016 indicated they were occasionally incontinent of bladder. Interview with registered staff #101 confirmed that the two assessments were not consistent with or complemented each other. [s. 6. (4) (a)]

5. 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 care set out in the plan was no longer necessary.

A) On an identified date in April 2016, resident #022 was observed with a device applied. Review of their plan of care stated the resident could release the device. Interview with PSW #124 reported the resident was unable to release the device. Registered staff #126 reported the resident used to be able to release the device; however, was no longer able to and their plan of care was not revised when their care needs changed.

B) On an identified date in April 2016, resident #007's bed was observed with two bed rails raised. Review of the plan of care identified they used one bed rail in the raised position when in bed for bed mobility and transferring. Interview with registered staff #104 stated the resident had two bed rails on their bed and confirmed the written plan of care was not reviewed and revised when their care needs changed and care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that there is a written plan of care for each resident that sets out the planned care for the resident, the written plan of care sets out clear directions to staff and others who provide direct care to the residents, staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and the resident is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #7: 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 the plan, policy, protocol, procedure, strategy or system put in place was complied with.

The home's policy, "Nutrition & Hydration - Monitoring Residents Weight & Height, Section C.1", revised November 2013, stated:

i) All weights are to be completed and entered into Point Click Care (PCC) by Registered Staff by the 10th of the month. If a resident has a loss/gain of 2.0 kilograms (kg) over one month, a reweigh must be done immediately or within 48

hours by the health care staff. The old weight is struck out and new weight recorded. Once the weights have been entered, the Nutrition Manager or Registered Dietitian is responsible to review all weight exceptions. Residents who have lost or gained a significant amount of weight defined as 5 per cent in one month, 7.5 per cent in three months and 10 per cent in six months are to be followed up by the RD immediately and documented.
ii) After admission, heights are then required annually by the health care staff. All heights are to be taken and recorded in centimeters (cm).

A) Resident #007's plan of care stated they were at nutrition risk related to multiple risk factors.

i. In January 2016, the resident's initial weight record indicated they had a weight loss of 8.2 per cent over one month and a re-weigh was not documented several days after the 10th day of January 2016.
ii. In March 2016, the initial weight record indicated they had a weight loss of 13.9 per cent over one month and a re-weigh was not documented until several days after the 10th day of March 2016.
iii. In April 2016, the initial weight record indicated they had a weight loss of 7.5 per cent over one month and a re-weigh was not documented until several days after the middle of the April 2016.

Interview with PSW #110 reported residents who had a change of 2.0 kg over one month were automatically re-weighed; however, documentation of re-weigh was not included in the resident's clinical record. Interview with dietary staff #154 reported they were responsible to request re-weighs for residents noted with a change of 2.0 kg over one month throughout the home, between the 12th to 15th day of the month, and estimated they requested re-weighs for approximately 20 residents each month. Interview with the RD who confirmed that resident #007, who experienced significant weight changes greater than 2.0 kg over one month, was not re-weighed according to the home's policy and the resident's clinical record did not include clear documentation of re-weighs occurring to ensure the nutrition manager and RD had accurate information by the 10th day of the month.

B) Resident #007 was admitted to the home in 2013. Review of their clinical record revealed no height recorded since 2013, as confirmed by registered staff #107. Resident #006 was admitted to the home in 2012. Review of their clinical record revealed no height was recorded since 2012, as confirmed by registered staff #126.

Interview with PSW #110 reported height was recorded in inches and converted to centimetres. PSW #124 reported they were only provided direction to measure height of residents standing and did not know how to measure height of residents unable to stand. Interview with registered staff #136 confirmed heights were taken in inches and converted to centimeters and that heights had not been measured and recorded annually. [s. 8. (1) (b)]

2. The home's procedure, "Bowel Routine", Section II", effective January 2014, had a decision algorithm for resident routine that outlined: Day 2 - no bowel movement: provide a laxative in the evening according to established bowel routine for resident, monitor for results next day. Day 3 - no bowel movement: repeat laxative in the evening. If no bowel movement by morning, give glycerin suppostory and dulcolax supp or one fleet enema as per resident's bowel routine. If the resident has not had a bowel movement (BM) by day 4, call the physician for further interventions.

Resident #007's bowel continence record from December 2015 to April 2016 was reviewed. In comparison to their medication administration record, medical directives record and progress notes, documentation revealed that on 15 occasions, the home's bowel protocol was not implemented, nor was the physician notified of the ongoing constipation when the policy directed the home to do so. Interview with the DOC who confirmed the home's bowel protocol was not followed. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that 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 complies with that the plan, policy, protocol, procedure, strategy or system, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection(1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

A) On an identified date in April 2016, resident #008 was observed with two positioning devices applied. Review of their plan of care did not include the use of both devices. Interview with registered staff #107 stated the resident required the devices due to a previous injury and were at risk of falling. Interview with registered staff #104 stated the resident was positioned with the devices as PASDs and confirmed they were not included in the plan of care. [s. 33. (3)]

2. The licensee failed to ensure the use a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following are satisfied:

1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

On an identified date in April 2016, resident #010 was observed with a positioning device applied. Review of their plan of care indicated the device was used for positioning and to prevent skin breakdown, however, no documented alternatives for the use of the PASD were found in their clinical record. Registered staff #101 confirmed there was no consent for the use of the device or noted alternatives for its use. [s. 33. (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 and ensure that a PASD described in subsection (1) of s. 33 is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, and; the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations, and
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #9: 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 has 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, and while asleep if clinically indicated.

Resident #003's plan of care identified they required total assistance with all activities of daily living. A wound assessment from April 2016, identified that they had a facility acquired area of skin breakdown related to pressure. The plan of care directed staff to turn and reposition the resident every two hours when in bed and every forty-five minutes when sitting.

i. On an identified date in April 2016, the resident was transferred from chair to bed. Staff did not turn and reposition the resident for two hours and forty-five minutes later. Interview with PSW #129 confirmed that the resident was put back to bed and was not repositioned for three hours, when the LTC Homes Inspector inquired about the resident's turning and repositioning schedule.

ii. On an identified date in April 2016, the resident was observed sleeping on their right side. The resident was not observed to be turned and repositioned until two and a half hours later, at which time, the resident was provided with morning care. Interview with registered staff #130 confirmed that the resident had ongoing areas of altered skin integrity and required the assistance of staff for turning and repositioning every two hours when in bed.

iii. On an identified date in April 2016, for three hours, the resident was observed laying on their back with the head of the bed at approximately thirty degrees and legs elevated. The resident was observed in the same position for three hours, at which time, the volunteer coordinator raised the head of the bed to visit with the resident.

Observations made on three identified dates in April 2016 revealed the resident was not turned and repositioned every two hours when in bed, as required in their plan of care. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that 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, and repositioned while asleep if clinically indicated, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

On an identified date in April 2016, PSW student #128 was observed providing total assistance to resident #023 with eating. The resident was seated in a reclined position. Interview with registered staff #126 reported the resident required total assistance with eating and was to be in an upright position for meals, and confirmed they were not in a safe feeding position. [s. 73. (1) 10.]

2. The licensee failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide assistance.

Resident #020 and #021's plans of care indicated they required total assistance with eating, as confirmed by dietary staff #114.

On an identified date in April 2016, resident #020 and #021 were observed seated at their tables with beverages in front of them. Thirty minutes later, PSW #121 started to provide total assistance to resident #020 and #021, at which time their beverage glasses were found not cool to touch. FSM #115 reported in an interview that the home's process at meals was to distribute milk and water for all residents at meals no earlier than 1145 hours; however, confirmed residents who required total assistance with eating were not to be served until someone was available to provide assistance. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for cleaning of the home, including,cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: (i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs, (ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids,

On identified dates in April and May 2016, baseboards in resident #013's room were observed to be covered with white residue. Environmental staff #120 stated that the method of cleaning used in the home was not effective in removing the residue. Review of the home's housekeeping policies revealed no procedures on cleaning of baseboards in residents' room, which was confirmed by the Program Director. [s. 87. (2) (a)]

2. The licensee failed to ensure that procedures were developed and implemented for cleaning and disinfection of resident care equipment, supplies and devices, including personal assistance service devices, assistive aids, and positioning aids and contact surfaces, using hospital grade disinfectant and in accordance with manufacturer's specifications.

On identified dates in April 2016, resident #012's mobility device was observed soiled with dry residue. Registered staff #101 reported PSW on night shifts were responsible for cleaning mobility devices and records of cleaning were kept on POC and/or the night duty sheets. Review of POC and night duties sheets revealed that the resident's mobility device was not cleaned on weekly basis from April 15 to 29, 2016, which was confirmed by DOC. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee will ensure that procedures are developed and implemented for the cleaning of the home, including resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, as well as cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices for supplies and devices, including personal assistance services devices, assistive aids and positioning aids, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

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

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

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 applied the physical device in accordance with any manufacturer's instructions.

On an identified date in April 2016, resident #007 was observed with a device applied more than eight finger widths from their torso. Review of the plan of care indicated the device was applied as a restraint. Interview with the rehab coordinator reported the manufacturer's instructions stated the device would be fitted tightly across the lower pelvis or thighs at all times. Registered staff #123 confirmed device was too loose and adjusted it to two finger widths from the torso. [s. 110. (1) 1.]

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

On an identified date in April 2016, resident #007 was observed with a device applied. Review of their plan of care indicated they were at high risk for falls. PSW #112 and registered staff #157 stated they were at high risk for falls and the device was used for falls prevention. Interview with registered staff #104 stated the device was a restraint and confirmed there was no order for the use of the device until the next day. [s. 110. (2) 1.]

3. The licensee failed to ensure that there was documentation in the clinical record to confirm that consent for the use of restraining devices was obtained prior to the use of restraining devices.

Resident #007 was being restrained by the use of a device to prevent falls. Review of the plan of care and interview with registered staff #104 confirmed that the home did not have consent from the resident's SDM to apply the device until after LTC Homes Inspector identified the device was not properly applied on an identified date in April 2016. [s. 110. (7) 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 and ensure that 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, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD used under section 33 of the Act, was applied by staff in accordance with any manufacturer's instructions.

A) Resident #022's plan of care stated they used a positioning device as a PASD related to impairments.

On an identified date in April 2016, the resident was observed with a device applied which was visibly loose. PSW #124 reported the resident was unable to release the device and that the manufacturer's instructions were to leave no more than a space of two fingers between the resident and the device. Registered staff #126 confirmed the device was used as a PASD, that the resident was unable to release the device and that it should be applied according to manufacturer's instructions.

B) On an identified date in April 2016, resident #008 was observed with a positioning device which was visibly loose. Registered staff #107 confirmed the device was too loose and the rehabilitation coordinator adjusted the device to two finger widths from their body. [s. 111. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that a PASD used under section 33 of the Act is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

In September 2014, resident #041 was prescribed an identified dose of medication every hour, as needed, for comfort. Approximately one week after the medication was initiated, a dose ten times the strength of the original was given in error. Review of the plan of care identified that the physician and SDM were notified and the resident was sent to the hospital but did not require treatment. The home's investigation notes confirmed that registered staff #136 provided the incorrect strength of the medication. Registered staff #136 did not administer medication to resident #041 as ordered by the prescriber, as confirmed by the DOC. [s. 131. (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 and ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, 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).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

The home's policy, "Infection Control - Routine Practices", last revised January 2013, directed staff to initiate droplet transmission precautions for a resident who had symptoms of an acute viral infection, consideration be given to maintaining a two metres spatial separation from the other residents and from visitors, participation in group activities may need to be adjusted or restricted when the resident is symptomatic, roommates and visitors must be aware of precautions to follow.

In February 2016, resident #003 was transferred to the hospital for treatment of infection. Review of the plan of care identified that the resident began displaying symptoms on a specified date in February 2016 and required administration of a medically directed intervention. A progress note on that initial day described the presence of symptoms of infection but did not identify that droplet transmission precautions were initiated. Interview with registered staff #119 confirmed that droplet precautions were to be initiated when any resident displayed two or more symptoms of a specified infection; and although, resident #003 had displayed two symptoms of infection, precautions were not initiated because the resident remained in bed, including but not limited to a sign on the door instructing staff and

visitors, notifying roommate (as applicable), and providing personal protective equipment at the door. Interview with registered staff #136, who was also the Infection Prevention and Control Lead, confirmed that droplet precautions should have been initiated with the development of symptoms on a specified date in February 2016, as outlined in the home's infection control policy. [s. 229. (4)]

2. The licensee failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On an identified date in February 2016, resident #003 developed new symptoms of infection. A medical directive was administered to the resident for two days. The following day, as a result of worsening symptoms, the physician was notified and made new orders for medication as well as further assessment. The following day, the resident was transferred to the hospital and was treated for an infection. Review of the plan of care did not include any monitoring of symptoms of infection on the evening and night shift the first day symptoms appeared, on any shift the second day and on the evening and night shift on the third day. Interview with registered staff #136 identified that residents with new symptoms of infection are to be monitored by registered staff and documented in the progress notes. If an outbreak is identified, then the symptoms were to be monitored on the home's line listing. Registered staff #136 also revealed that the home had been in outbreak in January 2016 and at the end of February 2016 (in a different home area), but the resident was not included on the home's outbreak line listing. Registered staff #136 confirmed that after the resident displayed new symptoms of infection, they should have been monitored every shift by registered staff in the progress notes. [s. 229. (5) (a)]

3. The licensee failed to ensure that staff on every shift recorded symptoms of infection in residents and take immediate action as required.

i) In a January 2016 MDS assessment, resident #004 was coded with a diagnosis of an infection. Review of their clinical record revealed they began demonstrating symptoms of infection on an identified date in January 2016 and began treatment the next day. Documentation did not reveal that staff consistently monitored or recorded symptoms of infection on every shift when the resident was exhibiting symptoms and receiving treatment.

ii) In a February 2016 MDS assessment, resident #009 was coded with a

diagnosis of an infection. Review of their clinical record revealed they began demonstrating symptoms of infection on an identified date in February 2016 and began treatment the following day. Documentation did not reveal that staff consistently monitored or recorded symptoms of infection on every shift when the resident was exhibiting symptoms and receiving treatment.

Interview with registered staff #136 reported the home's practice for monitoring symptoms of infection was to assess the resident each shift and document only when there were changes in symptoms, and confirmed staff did not record symptoms of infection on each shift when resident #004 and resident #009 were exhibiting symptoms of infection. [s. 229. (5) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that all 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 O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Resident #060's plan of care identified that they required the assistance of staff for bathing twice a week. Review of POC documentation for bathing in February, March, and April 2016 and an interview with PSW #131, revealed that the resident did not receive their scheduled bath three times in February 2016; once in March 2016; once in April 2016 and bathing was not made up at a later time.

B) Resident #044's plan of care identified that they required the assistance for bathing twice a week. Review of POC documentation for bathing in February, March and April 2016 and an interview with PSW #148, revealed that the resident did not receive their scheduled bath twice in February 2016; once in March 2016; twice in April 2016 and bathing was not made up at a later time.

Interview with PSW #131 and PSW #148 confirmed that when staff were unable to complete bathing, "not applicable" was documented and it was usually difficult to make up baths the next day. [s. 33. (1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

During the course of the inspection, heavy amount of hard water scale deposits were observed on shower faucets and wall tiles in Twin River Court shower. Corroded facets covered with white hard water deposits were also observed in resident #012's and #013's bathrooms.

i. Review of the home's preventative maintenance policies and procedures manual included under the general equipment section that an inspection of water faucets and aerators was to be completed on monthly basis by maintenance personnel. Interview with maintenance staff #121 reported they used notes completed by staff in the maintenance binder to address remedial maintenance issues and was unaware of the preventative inspection requirement for water faucets and aerators.

ii. Review of the home's maintenance policies and procedures did not include any preventative maintenance procedures or routines to remove hard water scale and iron deposits from tiles, fixtures and faucets. The Administrator confirmed that there were no procedures developed related to hard water scale removal. [s. 90. (2) (d)]

Issued on this 20 day of June 2016 (A2)

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

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
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Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LEAH CURLE (585) - (A2)

Inspection No. / No de l'inspection : 2016_343585_0007 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 010808-16 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jun 20, 2016;(A2)

Licensee / Titulaire de permis : PARK LANE TERRACE LIMITED
284 CENTRAL AVENUE, LONDON, ON, N6B-2C8

LTC Home / Foyer de SLD : PARK LANE TERRACE
295 GRAND RIVER STREET NORTH, PARIS, ON, N3L-2N9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Joe-Anne Holloway

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

To PARK LANE TERRACE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_343585_0015, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall:
A. continue to use their comprehensive bed safety assessment tool using as a guide the US Federal Food and Drug Administration document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003",
B. ensure that interdisciplinary assessments of all residents, including resident #007, resident #008, resident #010 and resident #076 are completed, using the bed safety assessment tool and results and recommendations of the assessment are documented,
C. ensure all health care records are updated to include why bed rails are being used, how many are to be used and any accessories that are required to mitigate any identified entrapment or safety risks,
D. re-educate all health care staff with respect to when to apply bed rails for each resident, why they are being applied and general bed safety hazards,
v. ensure residents who have any change in their bed system are re-assessed using the bed safety assessment tool; and
vi. conduct audits on an ongoing basis to ensure that bed safety assessments have been completed for all residents and care set out in in the plan of care related to their bed system is implemented as specified in the plan.

Grounds / Motifs :

1. Previously issued as a compliance order (CO) in August 2015

2. Previously issued as a voluntary plan of correction (VPC) in April 2014.

3. The non-compliance issued was determined to have a severity of 'potential for actual harm/risk' with a scope of 'isolated'.

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

A) On an identified date in April 2016, resident #008's bed was observed with two bed rails raised. A review of their clinical health record revealed that a bed rail assessment was completed in July 2015 which stated they required the use of one

bed rail as a personal assistance services device (PASD). Interview with personal support worker (PSW) #105 reported the resident used two bed rails for repositioning and bed mobility. Interview with registered staff #104 stated the bed rails were changed in October 2015 and confirmed an assessment of the bed rails being used at the time of the inspection was not completed.

B) On identified dates in April 2016, resident #010 was observed in bed with two bed rails raised. Review of the their clinical record revealed no assessment was completed for the use of the bed rails. Interview with the resident and registered staff #101 stated they used two bed rails for transferring and bed mobility. Registered staff #101 confirmed an assessment of the bed rails was not completed.

C) On an identified date in April 2016, resident #007's bed was observed with two bed rails raised. Review of their clinical health record revealed that a bed rail assessment was completed in October 2014 which stated they required one bed rail for transferring and bed mobility. Interview with registered staff #104 stated the resident's bed rails were changed in October 2015 and confirmed an assessment of the two bed rails being used was not completed.

D) On an identified date in April 2016, resident #076 was provided with a change of bed with bed rails; however, the bed system was not tested for zones of entrapment until the next day. Housekeeping staff #116 who completed the assessment stated the bed system failed zones two and four and confirmed that the resident's bed system was not tested for zones of entrapment prior to the resident sleeping one night with the bed rails in place. [s. 15. (1) (a)] (581)

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

Sep 30, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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)

Linked to Existing Order / Lien vers ordre existant: 2015_343585_0015, CO #004;

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall ensure:
A. staff use safe transferring and positioning techniques with all residents as identified in their written plan of care prior to transferring the resident,
B. re-education is provided to all direct care staff on transferring and positioning techniques for all residents related to safe transferring; and
C. all staff are following the plan of care for all residents, especially in relation to transferring, using methods and/or devices residents are assessed to require as per the home's Minimal Lift Policy and safe lift and transfer (S.A.L.T.) assessments.

Grounds / Motifs :

1. Previously issued as a compliance order (CO) in August 2015

2. Previously issued as a voluntary plan of correction (VPC) in May 2015.

3. The non-compliance issued was determined to have a severity of 'potential for actual harm/risk' with a scope of 'isolated'.

4. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) Resident #068's written plan of care as well as a Safe Lift and Transfer (S.A.L.T.) assessment completed in April 2016 identified that they were to be assessed daily and transferred with one or two person assist with a transferring device.

On an identified date in April 2016, the resident was observed being transferred with two staff but the staff did not use a transferring device. Interview with PSW #117 stated the resident was to be transferred with the device and confirmed they did not adhere to their designated transfer status. Interview with registered staff #101 stated that staff were to follow the logo at bedside and kardex which indicated a transfer device was to be used with all transfers and confirmed that staff did not use safe transferring and positioning devices or techniques when assisting resident #068.

B) Resident #043's written plan of care as well as a S.A.L.T. assessment completed in February 2016 identified that they required two staff assistance for transferring with a lift device and transfer device, which was to be assessed daily and was reflected on signs posted in the resident's room.

On an identified date in April 2016, resident #043 requested the assistance of staff to transfer, PSW #141 assisted the resident to a chair. Interview with PSW #141 who confirmed that on that shift, they provided supervision only with one staff present. Interview with PSW #145 confirmed that the resident required two person assistance for transfers with a transfer device. The resident was not transferred according to the designated lift/transfer status in their plan of care, as required in the homes "Minimal Lift Policy". [s. 36.] (581)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 :

Jul 15, 2016

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2015_343585_0015, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that:
A. drugs are stored in an area or a medication cart that is secure and locked,
B. all registered nursing staff are educated on the requirement that drugs are to be secure and locked when unattended, including but not limited when they are administrating and dispensing medications to residents,
C. audits are conducted on an ongoing basis to ensure drugs are kept secure and locked,
D. remedial actions, including but not limited to counseling of staff, are taken as required; and
E. a record of all education provided as well as completed audits are maintained

Grounds / Motifs :

1. Previously issued as a CO in August 2015.

2. The non-compliance issued was determined to have a severity of 'potential for actual harm/risk' with a scope of 'isolated'.

3. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

A) On April 18, 2016, at 1524 hours, the medication room door was observed to be propped open and a medication cart was located inside the room. Registered staff #133 was seated in the chart room beside the medication room. The Long-Term Care (LTC) Homes Inspector was able to enter the nurses station and medication room, without registered staff #133 being aware. Medication cupboards in the medication room and drawers in the medication cart were opened. Over ten minutes later, registered staff #133 noticed the LTC Homes Inspector in the medication room and confirmed that the cart and room should have been locked when unattended. (528)

B) On April 20, 2016, in the afternoon, registered staff #134 was observed dispensing and administering medications to residents on Heritage South home area. From 1530 hours, for approximately 10 minutes, registered staff #134 dispensed and then administered medications to three residents in their rooms. The medication cart was left in the hallway while registered staff #134 entered the resident rooms. The

cart was not locked at any time during the observations. Interview with registered staff #134 confirmed the cart was left unlocked when unattended. (528)

C) On April 28, 2016 at approximately 1400 hours, a medication cart was observed in front of the Heritage front desk, facing the residents lounge, was noted to be unlocked. The LTC Homes Inspector was able to approach and open the medication cart drawers without any registered staff becoming aware. Resident and families were observed visiting in the immediate areas around the cart. Registered staff #100 confirmed that the cart was left unlocked by mistake. (528)

D) On April 28, 2016, at 1515 hours, the medication cart located behind the front desk of Heritage nursing area was observed unlocked. From 1515 to 1525 hours, registered staff in the Heritage workroom were unaware that LTC Homes Inspector had access to the cart and was opening the medication cart drawers. During the observation, non-registered staff were observed behind the front desk. At 1525 hours, registered staff #100 confirmed that the cart was not locked and secured when unattended. (528) (528)

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

Jul 15, 2016

Order # /
Ordre no : 004

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

Linked to Existing Order /
Lien vers ordre existant: 2015_343585_0015, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure that:

A. all residents are provided with a range of continence care products that, (i) are based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible, and (v) are appropriate for the time of day, and for the individual resident's type of incontinence,

B. the home provide, at no charge to the resident/representative a range of incontinent products that, are based on individual assessed needs or preferences as outlined in the regulations, including a pull up style product that meets the continence needs of the resident, effective immediately,

C. the home conduct an audit of all residents who have resided in the home in 2015 and 2016 to determine if they had used or are using a pull up style continent product; any resident identified will be re-assessed to determine if a pull-up style product is still a need or preference of the resident, and if so, the home provide a pull-up style product that meets their need,

D. the home will not charge for, or allow residents/representatives to bring in, incontinent products unless the resident/representative has requested the specific brand, which is not offered by the home and/or the use of the identified product is not an assessed need or preference for the resident; and

E. all staff who provide direct care to residents are provided education on the home's range of continence products which include a pull up style product, which are of no charge to residents and a record of the education as well as staff trained will be maintained.

Grounds / Motifs :

1. Previously issued as a compliance order (CO) in August 2015.

2. The non-compliance issued was determined to have a severity of 'potential for actual harm/risk' with a scope of 'pattern'.

3. The licensee failed to ensure that residents were provided with a range of continence care products that,

(i) were based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promoted resident comfort, ease of use, dignity and good skin integrity,
(iv) promoted continued independence wherever possible, and
(v) were appropriate for the time of day, and for the individual resident's type of incontinence.

A) Resident #074's plan of care indicated they required assistance for toileting and wore incontinent products. Review of the Resident Profile Worksheet, as well as the continence logo posted at bedside, identified they wore their own pull up style incontinence product. Interview with PSW #117 stated when the resident was admitted to the home, the family had provided a pull up style product; however, they ran out of their product and the resident was now wearing a different type of incontinence product as the home did not provide pull up style products. The resident stated they were wearing their own pull up product but were changed to a different product as they were told the home did not provide pull up products and indicated that they would prefer to wear a pull up style product as it allowed them to be more independent with toileting. Interview with registered staff #101 stated that the resident was using a pull up product that the family provided; however, was changed to a different product as the home did not provide a pull up style product and confirmed the resident was not assessed on their individual needs and preferences when they were changed from a pull up style product. The home did not provide a continent care product that promoted resident #074's comfort, ease of use, and independence.

B) Resident #072's plan of care indicated they required incontinence products. Interview with PSW #152 reported that the resident initially wore a pull up style product, which the resident supplied; however, when the pull up product supply was finished they were informed by the DOC to use a different incontinence product. Interview with the resident who stated they were using the products provided by the home; however, found they did not fit well and they preferred a pull up style product. The resident stated they were told by the home that they did not provide a pull up style product and they would have to buy the product themselves. Interview with the DOC confirmed that the resident was not provided with a pull up product from the home and was not assessed on their individual needs and preferences when they were changed from a pull up style product to a different incontinence product.

C) Resident #062's plan of care identified they were incontinent and required

supervision with some aspects of toileting, but would self-transfer to the bathroom. The resident reported that they used a pull up incontinence product which was their preference, that their family bought them as the home did not provide pull up style product. Interview with resident's family who stated the home showed them the incontinence products that they provided upon admission and they did not offer a pull up product, so the family continued to purchase them to maintain the resident's independence and comfort with toileting. Interview with registered staff #126 and PSW #151 who stated the home did not provide pull up style incontinence products and that resident's family was paying for the product and bringing it into the home. Interview with the DOC confirmed that the resident was not provided with a pull up style product from the home and was not assessed on their individual needs and preferences and the home was not providing a continent care product that promoted the resident's comfort, ease of use and independence. [s. 51. (2) (h) (i)] (581)

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

Sep 30, 2016(A2)

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all current and former residents since July 1, 2010, will be reimbursed for all costs for pull up style continence care products, that should have been provided at no charge, while the resident resided in the home.

This plan shall include:
i. an audit of all current and former residents to determine if they were charged for a pull up style incontinent product and the reason for the use of the product,
ii. the total number of individuals charged for the pull up products and the amounts to be reimbursed; and
iii. a schedule for reimbursement of these current and former residents/representatives for the full cost of the products used during their length of stay by March 31, 2017.

The home will submit their compliance plan results of initial audits by September 30, 2016, and their reimbursement plan for all current and former residents/representatives on a quarterly basis, to dianne.barsevich@ontario.ca, until March 31, 2017, at which time all costs incurred shall be reimbursed.

Grounds / Motifs :

1. The licensee failed to ensure that they did not cause or permit anyone to make a charge or accept such a payment on the licensee's behalf.

Ontario Regulation 79/10 section 245 paragraph 1 identified the following:
The following charges are prohibited for the purposes of paragraph 4 of subsection 91(1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, 1. A local health integration network under section 19 of the Local Health System Integration Act, 2006 including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act".

The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded

by the local health integration network under their service accountability agreement for continence care supplies.

The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCA or accommodation charges received under the LTCA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCA"

Section 51(2) of the Regulation under the LTCA identified the following:
"51. (2) Every licensee of a long-term care home shall ensure that, (f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and (h) residents are provided with a range of continence care products that, (i) are based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible and (v) are appropriate for the time of day, and for the individual resident's type of incontinence".

If a resident was assessed to require a pull up style incontinent product then it shall be provided as part of the range of continence care products to be provided at no charge by the home.

The licensee permitted the resident's representative to make a charge or accept a payment on the licensee's behalf for continence care products, which they received funding from the local health integration network under the service accountability agreement.

A) Resident #064's plan of care identified they required supervision and assistance for toileting and used a pull up style incontinence product. Interview with PSW #113

stated that the home did not provide pull up style products but they ordered the pull up product for the resident and the bill was sent to the family. Interview with the resident's substitute decision maker (SDM) stated that they were unaware the home provided pull up style products and confirmed that the home ordered the pull up style product from Cardinal Health and they were paying for the product for an identified period of time. Interview with the DOC confirmed that the resident wore a pull up style incontinence product which was ordered by the home; however, the bill was charged to the family by Cardinal Health.

B) Resident #070's plan of care indicated they required assistance for toileting and used a pull up style incontinent product. Interview with PSW #151 and the resident stated they were able to toilet themselves but required assistance some aspects of care. PSW #151 also stated that the home did not provide pull up style products and that the families paid for the product. Interview with the DOC confirmed that the resident wore a pull up style incontinence product which was ordered by the home; however, the bill was charged to the family by Cardinal Health.

C) Resident #074's plan of care identified they required assistance for toileting and used a pull up style incontinent product. The resident stated that they had been wearing a pull up type product that they provided but they did not have any more so they were now using different type of incontinence product provided by the home. The resident's family reported in an interview that when the resident was admitted to the home, the home stated they provided various continence products; however, did not specify a pull up type product. Further, they reported the resident would be reassessed when their pull up products ran out. The family stated they were aware the incontinence product was changed non-pull-up type product; however, the resident did not like the change in product, preferred a pull up style product and that the resident asked if they would purchase a pull up product for them. The family reported they purchased pull up style incontinent product for the resident. Interview with PSW #117 stated that the resident was wearing a pull up product which the family provided but when the supply was finished, they changed to a different product as the home did not supply pull up incontinence products. Registered staff #101 confirmed the resident was not provided with a pull up style incontinent product from the home and family were still buying the pull up style incontinent product for the resident. [s. 91. (4)] (581)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 :

Mar 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 20 day of June 2016 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : LEAH CURLE - (A2)

Service Area Office /
Bureau régional de services : Hamilton